Women´s perception about female vulnerability to STD and HIV*

A PERCEPÇÃO DE MULHERES QUANTO À VULNERABILIDADE FEMININA PARA CONTRAIR DST/HIV

LA PERCEPCIÓN DE MUJERES EN LO QUE SE REFIERE A LA VULNERABILIDAD FEMENINA PARA CONTRAER DST Y HIV

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ABSTRACT

This is a descriptive study using a qualitative approach. The purpose was to analyze women's perception about female vulnerability to acquire STD/HVIV. The study took place in 2006 at a university campus in the city of Rio de Janeiro. Interviews were carried out with 12 women, older than 18 years, of different educational levels, ethnic origins and religions. The women were students, technical-administrative workers and faculty members, among other users. The study complied with the requirements of the National Research Ethics Committee. Data analysis was performed according to the premises of Content Analysis. Results revealed two large dimensions: one related with the women's personal perception and their behaviors, and another related with these women's opinion about other women's behavior. This article discusses the data regarding the collective dimension. It was concluded that the interviewed women recognize vulnerability factors in other women and realize the risk that *others* face of acquiring STD/HIV, but do not consider themselves to be at risk.

KEY WORDS

Women´s health.
Gender and health.
Sexually transmitted diseases.
HIV.
Vulnerability.

RESUMO

Pesquisa descritiva com abordagem qualitativa cujo objetivo foi analisar a percepção de mulheres quanto à vulnerabilidade feminina para contrair DST/HIV. Foi realizada em 2006, num campus universitário no Rio de Janeiro. Foram entrevistadas 12 mulheres, de idade superior a 18 anos, de diferentes níveis de escolaridade, raça e religião. Estas eram estudantes, servidoras técnico-administrativas, docentes e outras usuárias. Foram atendidas as exigências do Conselho Nacional de Ética em Pesquisa. Os dados foram analisados segundo os pressupostos da Análise de Conteúdo. Os resultados revelaram duas grandes dimensões: uma que relaciona a percepção pessoal da mulher e seus comportamentos, e outra relacionada à opinião dessas mulheres sobre o comportamento de outras mulheres. Neste artigo discutimos os dados referentes à dimensão coletiva. Concluímos que as mulheres entrevistadas reconhecem os fatores de vulnerabilidade nas outras mulheres e percebem o risco do *outro* em contrair DST/HIV, porém não se consideram em risco.

DESCRITORES

Saúde da mulher.
Gênero e saúde.
Doenças sexualmente transmissíveis.
HIV.
Vulnerabilidade.

RESUMEN

Investigación descriptiva con abordaje cualitativo, cuyo objetivo fue analizar la percepción de las mujeres en lo que se refiere a la vulnerabilidad femenina para contraer DST/HIV. Fue realizada en un campus universitario, en Río de Janeiro, en 2.006. Fueron entrevistadas 12 mujeres, de edad superior a 18 años, de diferentes nivele de escolaridad, raza y religión. Estas eran estudiantes, servidoras técnico administrativas, docentes y otras usuarias. Fueron atendidas las exigencias del Consejo Nacional de Ética en Investigación. Los datos fueron analizados según los conceptos del Análisis de Contenido. Los resultados revelaron dos grandes dimensiones: una que relaciona la percepción personal de la mujer y sus comportamientos, y otra relacionada a la opinión de esas mujeres sobre el comportamiento de otras mujeres. En este artículo discutimos los datos referentes a la dimensión colectiva. Concluimos que las mujeres entrevistadas reconocen los factores de vulnerabilidad en las otras mujeres, perciben el riesgo del *otro* para contraer DST/HIV, sin embargo no se consideran en riesgo.

DESCRIPTORES

Salud de la mujer.
Género y salud.
Enfermedades de transmisión sexual.
VIH.
Vulnerabilidad.

* Extracted from the monograph: "A autopercepção de mulheres quanto à sua vulnerabilidade para contrair DST/HIV", Faculty of Nursing, Rio de Janeiro State University, 2006

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Portuguese / English:
www.scielo.br/reeusp

Received: 08/30/2007
Approved: 09/03/2008

INTRODUCTION

Sexually transmitted diseases (STDs) are frequent all over the world. They cause potentially serious complications, such as the risk of infertility, abortions and congenital infections. They also facilitate HIV infection. The World Health Organization (WHO) estimates 10 to 12 million new STD cases in Brazil every year[1].

The increased incidence of STDs has become a serious problem in public health, worrying the scientific community and the governments, especially regarding the Human Immunodeficiency Virus (HIV). The large number of cases of heterosexual transmission have increased the participation of women in the epidemiologic profile of the disease, observed in the progressive reduction of the gender ratio among all categories of exposure, from 15.1 men for 1 woman in 1986 to 1.5 man for 1 woman in 2005[2]. This observation also increased concerns with vertical transmissions, leading to more investments in the early detection of the virus in pregnant women and in healthcare education, in an attempt to prevent its transmission to children, so as to avoid new cases of AIDS[3-4].

The interpretation of these factors, especially regarding the gender differences, exposed the vulnerability of women to acquire the virus. As such, the goal was to analyze the perception of women about the feminine vulnerability to acquiring STDs/HIV.

LITERATURE REVIEW

In this study, it is essential to address the concepts of gender and gender relationships, since these are connected with the themes of vulnerability, sexuality, STD and nursing actions. These are related to the differences between men and women. This comprehension will allow for a reflection on the biologic gender and the identity built by the individuals and society.

Defining the word *gender* is a complex task, since it is related with the social and subjective spheres, influencing several situations. Gender is the form of identifying the social constructions with the idea of different roles for men and women. It is a way of reporting the exclusively social origins of the subjective identities of men and women[5].

For a long time, the social construction of the history of women is based on the submission to men, on inferiority and inability to equate the genders. So far, the relationship between men and women is based on outlining different roles, favoring men somewhat, allowing them to have unequal opportunities when compared to women.

Women have been victims of a process of undervaluation of their work, both in the formal market and in household chores, which are considered women's duty. Some of the aggravating factors for women are highlighted, such as wage differences, social devaluation of certain occupations and the women's triple work shift[6].

> The differences and inequalities that (still) distinguish men and women in the modern world are relatively large, even though their content has changed over time, to the point of masking reality for many people who insist on not seeing it according to the universality of the social phenomena[7].

The feminist movement reflected on the *issue of the women*, as women had noticed that there were differences in the treatment given to men and women in society. When they gathered to discuss the situation of women, they would think about who these women were. They started to discuss the expression *being a woman is...* With that, however, they were at risk of leaving important parts out of the definition of what we will politically name struggle against gender inequality. An example of that is the fact of using maternity for the definition, which would exclude women who could not or who chose not to have children. Therefore, at first, they had an anatomic perception, i.e. they had fewer rights because they were born as women[8]. However, it is worth noting that this anatomic problem was not biologic, but cultural. Culture would not work either, since it varies according to place, races and social class. This gave rise to the conception of gender that has sought to emphasize the social characteristics of the differences and to expose the relations between genders.

Vulnerability and women

The context of the many challenges to cope with the AIDS epidemic yielded the concept of vulnerability.

> The conception of HIV/AIDS vulnerability expresses an effort to produce and spread knowledge, debate and actions about the different degrees and natures of the susceptibility of the individuals and groups to infection, to falling ill or to death by HIV, according to the particular aspects of their situation and the integrated set of social, programmatic and individual aspects that relate them with the problem and the resources used to cope with it[8].

As such, we can understand that vulnerability is a concept that has been used since the 1990s to reflect on and build actions focused on the prevention of HIV/AIDS. This situation points to a group of factors, levels and magnitudes where interaction exerts influence on increasing or reducing the possibilities of a person's infection with HIV, permitting the planning of preventive interventions[8].

The vulnerability of a given group to infection and to falling ill due to HIV is the result of several characteristics of the political, economic and socio-cultural contexts that increase or reduce the individual risk. In addition to the work developed on social vulnerability, there is a great challenge in improving long-term healthcare and prevention programs in order to understand structural prevention difficulties and access. Also, it is a challenge for the many experiences with the available prevention means, also known

as programmatic vulnerability. In the scope of individual vulnerability, every individual can really become protected from infection and disease[9].

The increased incidence of HIV/AIDS among women not only indicates difficulties to offer institutional answers to restrain the epidemic but, overall, it focuses on gender issues, which built the social roles of men and women. Their asymmetry increases the vulnerability of women to infection, becoming an obstacle to the perception of the vulnerability to HIV infection or re-infection[10].

It is known that gender inequality has caused historic submission and inferiorization of women. Women are still unable to exert their decision power in public and private life; they still receive salaries that are lower than men's in the same positions, and are hit hard by daily, domestic and sexual violence. Women have less freedom in their sexual life and less decision power regarding safe sex. Therefore, these inequities make women more vulnerable to the epidemic[11]. Thus, it is extremely important to elaborate preventive strategies that are focused not only on the women in the target group, as men should also be involved in a process of change, since their behavior affects the women directly.

METHOD

This is a descriptive study with a qualitative approach, performed on a college campus in the city of Rio de Janeiro, Brazil. The study subjects were randomly selected women, aged 18 or older, with different levels of education, races and religions. This group includes students of the many courses, technical-administrative workers or professors, as well as the other users of the Campus facilities. All requirements of the National Health Council were met[12]. The project was submitted to the Ethics Committee of Hospital Universitário Pedro Ernesto – UERJ, file #1375, on February 2, 2006. Data was collected through audio recordings in February 2006 and transcribed for later analysis. The interviews were held in private locations, maintaining the privacy of the interviewees. Data analysis was performed according to the precepts of Content Analysis[13]. The interviews were submitted to floating readings, highlighting their registry units.

RESULTS AND DISCUSSION

The interviews were held in places chosen by the respondents themselves, within the campus areas. The information saturation criterion was used to determine the number of subjects. As such, the group of respondents consisted of 12 women, who were mostly single and 18-38 years of age.

The analysis of the data yielded two large dimensions for the studied phenomenon, each consisting of different theme categories. The first, named personal dimension, relates the respondents' perception of the self and their behaviors; the second, named collective dimension, covers the opinions of these women about other women. This article analyzes and discusses the data about the collective dimension.

Collective Dimension

The collective dimension was seen as divided in three categories and their respective subcategories, which are described next.

The first category, *perceiving AIDS as a disease of other women*, made it evident that the interviewees considered women in general as vulnerable. However, many of them did not consider themselves at risk, i.e. excluded themselves from the condition of being women and spoke of the others as having the potential to acquire STDs/HIV.

> Look, I think I can't answer that question, it depends, I see many people who are at risk of getting AIDS, having sex with many people without condoms, lots of people using drugs, I don't know if they share needles, I don't trust them (Interview #9).

> I think they do, whoever has it cannot trust men very much, can they? Because men go out, they have sex, they don't care much about it (Interview #7).

The idea of AIDS as a disease of the *others* was studied by different authors[14-17]. In our study, the *other* is shown as more vulnerable to acquiring the disease, and the women interviewed see themselves as supposedly protected. The *other* is the one who becomes contaminated by behaving *in such and such ways*, which would justify that contamination. In many cases, there is no concern with AIDS. This is based on a moral code, where marriage seems to guarantee *immunity* to the disease. It is a classificatory system that establishes clear limits as to who could acquire AIDS, these being promiscuous people, with stray behaviors and unruly lives; and those who could not acquire the disease, these being women with only one partner, where an affective relationship and love are present[14].

Another study showed that AIDS was something distant for the interviewed adolescents, since it is not part of their daily personal and social routines, confirming the idea that this is a disease *of the other*[14]. All women stated that they had not noticed the risk of infection and did not consider themselves vulnerable to HIV. As such, they did not take any protective measures against the virus. The women who denied the risk believed that HIV threatened other people, excluding themselves from the risk. They often did not perceive the risk because they did not consider themselves as part of the risk groups[15].

It was also observed that married women understand that these diseases are characteristic of promiscuous women, those who have sexual intercourse with several partners, as it is difficult for them to believe that their own husbands would have sex with those women[16]. The women interviewed associate a higher risk of contamination to *oth-*

ers, who are people who are not in stable relationships or who had risky behaviors. This would highlight the importance of the *others*, the need for awareness and changes towards safer behaviors, which would therefore result in a lower perception of vulnerability[17].

The second category, *associating the lack of condom use with higher vulnerability in women* is made up of three subcategories, where the interviewed women show reasons for not using condoms, such as men's resistance to using it, the difficulties for women to demand it and the embarrassment in disappointing their partners.

> It's very complicated, because the male justifications always favor not using it. […] Men usually think that it reduces their pleasure, or they feel embarrassed, their erections are not the same as they would be without the condom, they'd rather have sex without it, they feel safer and more masculine without the condom (Interview #1).

> She feels embarrassed in demanding certain things, because they think they'd be misunderstood. Usually men say that if a women demands protection, it's because she's promiscuous (Interview #8).

> Even the shame of disappointing their partner, I don't know, of being less pleasurable, of being something like, she wants to be nice and ends up screwing up (Interview #11).

Certain cultural characteristics should be highlighted on the topic of condoms. The use of condoms brings ideas of sexual behaviors that stray from the monogamous model, where loyalty and trust are well regarded. When men are asked to use condoms, they usually interpret this as a suspicious partner or an unfaithful wife. Often, this may lead to a social and personal risk that women are not willing to take, since this could result in discrimination, loss of their partner and social status[18]. Commercials encouraging the adoption of safer practices have little success in groups of women in stable relationships, for several reasons: the idea of demands in the sexual area is contradictory with the representations of love and sexuality that many women and men have as guidelines for their sexual encounters; for most couples, it is not common to talk about sex and forms of sexual protection openly, since conception is experienced as the women's responsibility and STDs are not commonly discussed among couples or by healthcare services[19].

In the interviews done for this study, the fact that men did not like to use condoms emerged as a factor of women's vulnerability. According to a study performed in an outpatient clinic in São Paulo with HIV-positive women[20], the men's refusal to use the condoms is still at the core of the problem. In many studies, the reasons that men give for not wearing condoms are that they dislike it, and that they can only feel their own orgasms and their partners' when they do not use condoms. Thus, they do not.

Another important factor that emerged from the interviews in this study was the difficulty to demand the use of the condoms, which corroborates a study[21] in which some women did not believe that the use of condoms was necessary, stating that they knew the other person well and that having to negotiate safe sex in stable relationships could lead to conjugal problems.

The third category, *acknowledging the women's factors of vulnerability,* has seven subcategories that show the general factors of women's vulnerability, according to the interviewees. They recognize that today's youth is more vulnerable, that women do not want to use condoms, women's gullibility and submission, affective dependency, loneliness and romanticism are factors of vulnerability. They also acknowledge that women who live liberally are vulnerable, and they consider the lack of information and trust in the partner as factors of vulnerability.

> Because today's youth is like this, they don't think too much about it, they have that thing of making out, but it used to be just kissing some time ago. Their making out today is not like that, you make out with one today and go to bed, tomorrow you make out with another and go to bed, and so on (Interview #2).

> I wouldn't know how to answer that. I don't know what goes through their mind, why they don't want it. For me, they don't want to take care of themselves (Interview #6).

> Sometimes people close to you, people with some education, intelligent women, but they are lonely from a sentimental perspective, so they are vulnerable. As such, I think they are. […] That would be in the heat of the moment, in the excitation of the moment, going towards the sentimental side, in the passion on one of those days, the person becomes vulnerable because she's lonely. The person may become vulnerable for other reasons, but I think that loneliness is the main reason (Interview #12).

> I would agree, because most women want to live liberally without criticism. Being open to relationships, I guess that makes things easier, doesn't it? (Interview #11).

> So, it ends up, like, why would she need protection? In the case of a married women that would be to avoid pregnancy, she'd never imagine that she will get an STD, so this makes her vulnerable, doesn't it? Trust. (Interview 10).

Young people see AIDS as a great risk for people their own age[22]. It is worth noting that adolescence is a transitional phase between puberty and maturity. In this period, some behaviors are forms of self-affirmation for the adult stage. It is a time for new experiences and discoveries, which can often entail irreversible risks, such as unwanted pregnancies or the acquisition of an STD/HIV[22]. The same was noted in this study, where the interviewed women saw young people as one of the most vulnerable groups.

Another factor of vulnerability reported by the women interviewed in this study was that women resisted using condoms. In a study done among men and women that were presumably heterosexual[21], women attributed low values to condoms and reported two types of justifications: one similar to men's, which is interference with sexual plea-

sure, the prevention of feeling the sperm during a sexual relation, the fear that the condom would rupture during the sexual intercourse and the fear of itches and irritation.

Female submission and gullibility, themselves the result of power differences between men and women, were mentioned by the interviewed women. In studies with women from the Camaragibe region[16], it was reported that they are raised with the affirmation of male power, submission and the duty of being a good and obedient wife and mother. They are often given incorrect information about marital and affective life by their own mothers, making them more vulnerable.

The women in this study mentioned affective dependency and the fear of losing the partner when demanding condoms as factors of vulnerability. We understand that women should invest in self-care, i.e. they should demand that condoms be used so that they can preserve themselves. However, for the woman, this type of investment may mean the loss of a partner who refuses to wear a condom. Hence, this is a moment of choosing between keeping the partner, exposing herself to risks, or forfeiting the partner[23].

The idea of *groups at risk* is still present in the perspective of some interviewed women, with their conservative opinions about women who live liberally. These conceptions strengthen the conception that their risk of contracting STDs/AIDS is reduced if they avoid going out or drinking alcohol. This can be verified in a previous study[15], where certain stereotypes *self-exclude* women with more reserved, socially-acceptable behaviors.

There are still people without information about contraceptive methods, which leaves them more vulnerable. This was mentioned by the interviewees. The lack of information is added to the idea that HIV infection is a distant thing, since the information the women had about AIDS prevention were not enough for successful prevention. In this study, done with HIV-positive women, the most important factors for infection were the lack of knowledge about the forms of transmission and prevention[15].

It is worth noting that women who are vulnerable because they trust their partners identify trust as a factor of vulnerability for other women, especially those who are married. The same occurred with women without fixed relationships, interviewed in another study[18]. Although they did not feel fully protected from AIDS, they do not consider that married people are protected, because they acknowledge the possibility of extramarital sex in married couples. In most heterosexual relationships, women tend to maintain a monogamous relationship with their partners. However, the opposite does not happen all the time, i.e. the sexual partner may not be exclusive[24].

FINAL CONSIDERATIONS

The idea that STDs/HIV are a disease of *the other* is common, and this can be verified in this study. The respondents identified higher risks of contamination in other women, due to certain behaviors and attitudes adopted. Among them, the trust placed in the partner is noted, since it results in sexual practices without protection.

Although preventive programs' emphasis lies on the use of condoms, this practice entails a group of situations where prejudices are stronger than reason. The study evidenced the suspicions of the partner, as well as the refusal of the partner to use it, and the possibility of wrecking their relationship with situations of social and personal risk that women are not willing to take.

This shows the great importance, for healthcare professionals, to invest in the empowerment of these women as a strategy to reduce gender inequities. We understand that less asymmetric relations are a decisive factor to reduce their vulnerability, as well as the incidence and prevalence of STDs/HIV.

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