

Reasons of Women for the Treatment and Prevention of Sexually Transmitted Infections

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ABSTRACT

Objective: To recognize the reasons that lead to the process of accession of women to the treatment and prevention of sexually transmitted infections.

Materials and methods: It is an exploratory research with a qualitative approach carried out with 20 participants in a city in the northeast of Brazil. Data were collected by means of semi-structured interviews with thematic content analysis.

Results and Discussion: From the establishment of the corpus and analysis of the content it was possible to identify meaning cores that were described in two categories: Treatment and Prevention: strengths and weaknesses; and Knowledge and reasons for prevention and treatment.

Final considerations: There was identified the reasons and weaknesses for women performing the treatment and prevention of STI's, which are: the need to overcome and test their own limits are indicated as reasons for accession to treatment and the inability to impose themselves against their partner is flagged as a fragility to access preventive measures. There was identified, yet, that women indicate certain dissatisfaction with the knowledge they have and realize that they need more information.

INTRODUCTION

Sexually Transmitted Infections (STIS) are a variety of clinical syndromes and infections caused by pathogens transmitted through sexual activity^[1]. The World Health Organization (WHO) estimates the worldwide occurrence of one million cases per day. The year the incidence is approximately 357 million between HPV, Chlamydia, Gonorrhoea, Syphilis

and Trichomoniasis, and the STIs among the major public health problems, both by the socioeconomic impact as the biopsychosocial impact related to sexual health, reproductive and maternal fetal [2,3].

Among STIS, acquired immunodeficiency syndrome (AIDS) is one of the most relevant that, although there are advances in therapies, campaigns and dissemination for prevention, there is still no cure or an effective vaccine, with consequent increase in the number of infected people, especially among individuals who are vulnerable. On the other hand, there is also the presence of comorbidities resulting from the combined antiretroviral therapy, which made the disease treatable, but chronic and with persistent viral replication. Thus, there is a need for the development of new technologies that make life easier for infected patients and, in this context, aptamers emerge as an interesting perspective in the health area, especially for patients with HIV [4,5].

Aptamers are single - stranded oligo nucleotides, functional antibodies analogues, but with the advantage that they can be chemically synthesized at reduced costs and thus attractive to developing countries. Its molecules acquire their own conformation, great binding force with their predetermined target, becoming highly specific. Several aptamers have been selected based on their ability to neutralize HIV and to act at various stages of its evolution, thus making great promise for HIV research, diagnosis and therapy [4,5].

Biological, cultural and social factors may favor the infection in women, since they are related to the anatomical characteristics, problems relating to a lack of knowledge associated to low schooling, difficult access to health services, use of condoms, early initiation of sexual activity and even by submission and promiscuity imposed by the spouse, making them a population with characteristics of vulnerability [6,7].

When present in women, can cause reproductive effects over time, including infertility, pregnancy complications, increasing the risk of acquiring HIV and cancer of the cervix of the uterus. During pregnancy, there is a risk of fetal maternal transmission, which can cause injuries to the neonate and consequently greater demand of care to women [8,9]. One study showed that one of the main reasons for the woman does not use a condom as a preventive method of IST's during sexual relations is the fact of not liking the condom, reflecting about the difficulty of accession to this method, even with access and necessary information [7].

In relation to the beliefs and concepts about prevention that can have an impact on access, we can verify in an investigation that people living with their spouse, in general, have no self-perception of vulnerability to STI, and thus end up not accessing the preventive measures. This factor contributes to the delay of early diagnosis, prejudice the proper treatment and generates major complications and transmission of the STIs [10].

The woman, when diagnosed with STI's, can be involved by a diversity of feelings, such as guilt, sadness, fear of death, anguish in transmitting the infection to their family and fear of interruption of bonds and coexistence, demonstrating the scenario of fragility of these women in society. Associated with these feelings, it is also noted prejudice and rejection on the part of the family, especially in relationship with the spouse [11].

Understand the reasons and motivations of women who reflect on their sexual behaviours and in preventive attitudes for the STIs provide data that can help health teams in the implementation of strategies to control the spread of STI's in this clientele, with increased adherence to treatment. Thus, this paper seeks to understand the reasons that lead to the process of accession of women to the treatment and prevention of STI's, with the aim of promoting the integral and humanized care to this population.

MATERIAL AND METHODS

This is an exploratory, descriptive, with a qualitative approach study carried out in May 2019, in a hospital located in a city in the countryside of the Brazilian northeast. This service is part of the public health network and meets currently, under outpatient, women who have several sexually transmitted diseases, in addition to performing prenatal and examination of Papanicolaou.

The group studied was composed by 20 women who met the following inclusion criteria: age above 18, having active sexual life and conduct follow-up at the outpatient clinic of gynaecology in the health service. The following women were excluded: those with any psychological alterations and/or communication that prevented from answering the guiding questions of the interview.

As a technique for data collection, we used a semi-structured interview with questions that met the objectives of the investigation and that were tape-recorded with permission of the participants. In response, there was used a guide for characterizing the socio-demographic profile of the group explored. With the aim of assuring transparency and demonstrate the scientific rigor adopted in this research, the recruitment of new participants was interrupted by theoretical saturation according to the criteria recommended by Fontanella et al. [12].

For the treatment and analysis of the data we used the technique of thematic content analysis following the steps proposed by Bardin ^[13], comprising the following steps: Reading the material by means of an exhaustive reading and floating of the content of the interviews after transcription in full; Exploration of the material by means of codification of information, cutting them into units of analysis and sorting them into categories. Thus, it is worth mentioning that the categories of analysis emerged from the narratives of women; Treatment of data, in which the information from the interviews were synthesized and, subsequently, confronted with the prior knowledge with the aim of making the information meaningful.

The present study has fulfilled the Resolution 466/2012 of the National Health Council and had its beginning after approval of the Ethics in Research Committee of the University Hospital of the Federal University of Maranhao, under Opinion N 3,301,617. All participants were informed about the research and signed the Informed Consent Form, being that each woman was identified by the letter M followed by a numbering system with the aim of ensuring the anonymity.

RESULTS

Of the 20 women interviewed, it was observed that the age ranged from 19 to 38 years old, the majority lived with their spouse (N= 14) and had a family income of up to one minimum wage in Brazil (the federal minimum wage is currently \$241.06 per month and has not changed since January 2019). In relation to schooling, only two had attended higher education, a higher incomplete and four with complete secondary education. The other had an average number of years of study for less than six years.

From the establishment of the corpus and analysis of the content, it was possible to identify meaning cores that were described in two categories: Treatment and Prevention: strengths and weaknesses; and Knowledge and reasons for prevention and treatment.

Treatment and Prevention: Potentialities and Weaknesses

From the record units that comprised the category "Treatment and Prevention: potentialities and fragilities" it was possible to identify the reasons, motivations and difficulties that guided the behavioural choices of these women to conduct their treatments, evidencing the potentialities and fragilities that permeate the decision of participants, as can be checked in the following extracts:

"I didn't abandon the treatment, because I wanted to get over it all." (M2)

"No, I didn't abandon the treatment, because I always wanted to do the right thing." (M17)

"I have not abandoned treatment, because I always go all the way in my battles. I made cauterization, I took medicine, did everything as it was indicated and thank God I was healed." (M15)

It can be observed that the treatment was undertaken in a positive manner, with good coping, based on the need to overcome and test their own limits, evidencing the empowerment of women in the conduct of their own life.

Besides the treatment prescribed by health professionals, women also reported the concomitant use of alternative therapies with the use of herbal homemade medications, showing the influence and impact of beliefs, cultures and regional values on the health factor, as demonstrated through the following narratives:

"I do both treatments. When I needed it, I was prescribed by the health care professional and the caretaker too." (M8)

"I did the treatment prescribed by the health professional and the concoctions I buy." (M2)

The validation of the homely medication by these women for preventive purposes was also mentioned by participants, highlighting the importance given to beliefs produced in their group membership:

"I do even prevention with the home remedies my mother does, to avoid any disease." (M6)

"As I said, I have never had any sexually transmitted disease and do prevention using the concoction." (M7)

Through the analysis units that make reference to the theme "Treatment and prevention", it was possible to identify even the fragility of women related to their submission to meet the desires of their partners, revealing that women still play a culturally rooted behaviour of subjugation of women to men, not feeling protected as the decision by the care of their own body:

"From 0 to 10, I note 9, because I know several diseases like Syphilis, HIV and Herpes and know what I should not do to get them, but my husband does not like to use condoms, because he prefers direct contact." (M9)

"I don't do prevention, because my husband doesn't like it and I end up accepting it." (M5)

Knowledge and Ineffectiveness of Information Related to Prevention and Treatment of STI's:

This category was composed by record units that validate how women apply the knowledge related to prevention and treatment and the lack of information about STI's. The participants indicate some sources of information that propagate knowledge about measures for prevention of STI's; however, explain that these are of questionable quality and insufficient, not contemplating their real needs. The narratives below illustrate some of these issues:

"Despite using a condom, I still have many doubts about other ways to get the disease." (M20)

"I know only what is said in some places or on conversation circles when we know that someone has such a disease." (M16)

It is perceived in the contents exposed that this lack of information may generate feelings of fear (the group investigated cited fear of death, fear of getting sick) and concerns related to the appearance of other diseases like cancer and complications arising from possible surgeries, leading them to become dependent on other people:

"I'm afraid of getting sick and not getting pregnant." (M10)

"What I want most is to get good from the disease and not run the risk of complications. So I prevent of getting sick and getting pregnant." (M4)

"I'm afraid to die or get dependent on someone if I have cancer." (M1)

"I'm afraid of getting a terminal illness, as the doctor told me that, in my case, this disease could evolve into cancer and die." (M5)

The feeling of shame and embarrassment by presenting a sexually transmitted disease before other people was also observed in the narratives:

"I felt very bad, smelled and very discharge in my panties, I was very ashamed, but I see no reason to wear condoms." (M11)

By analyzing the content exposed, it was possible to apprehend that from the group investigated absorbs the health information related to preventive methods of STI's and what are their motivations and justifications for using or not this information in their daily life, as demonstrated by the following narratives:

"From 0 to 10, I give myself note 7, but I do not prevent because I made ligation and do not see the need to use condoms." (M18)

"I give myself a note 8. I know we should prevent it, but I don't make prevention. I've never done anything to prevent, I've been married for over 20 years and I've never used anything." (M3)

"I give myself a note 8. The knowledge I have acquired through lectures in schools. I don't do prevention." (M20)

"I note 7, because I know some diseases like HPV, HIV and herpes and know that the best prevention is through male and female condoms. But I believe I don't need to do prevention because I'm married." (M16)

However, it was also possible to observe, through the units of analysis, reasons that generated positive attitudes to search by improving their health condition and their quality of life, as well as their protection and safety:

"(...) I seek to follow the advices to have quality of life and live well." (M11)

"I never had to do the treatment. But sometimes I use condoms for safety reasons." (M12)

"I haven't had to, and I hope I don't need it, but I'd do prevention for the sake of being healthy, I've predicted for safety." (M15)

DISCUSSION

In this research, we observed a great plurality of opinions regarding the reasons of women both to access the treatment, as well as preventive measures, showing the importance of the healthcare professional considering the individualities of each woman during the approach in health services in the context of the STI's.

Participants in the on-screen survey cited a diversity of sources of information about STD's, making the analysis of the reasons those motivate accession to treatment and to more healthy preventive measures, since the sources of knowledge directly influence the habits, behaviours and decision making, setting up a strong element to subsidize their communications with their social surroundings, reasons and choices.

Each social group has its own means of communication and information source that has a direct relationship with the social and educational level^[14]. In this research, the group of women exploited had a low level of schooling and low wage

income and cited as sources of information the trivial conversations in daily life and health professionals, when they sought care, revealing dissatisfaction in this aspect and leading us to question about the limitations of knowledge, especially in relation to the modification of risk factors for the onset of STI's.

Another factor to be considered is that the low schooling and low social status of women studied put them in a position of vulnerability for both risk and for transmission of STI's. A study performed in Iran pointed out that vulnerable women are more prone to high-risk behavior due to their special condition, which may have an impact in relation to the contamination of diseases in the social group, and the irreparable complications^[15].

The results showed that the fragility is not in the absence of information sources that these women enjoy, but in the questionable quality of such information and the ineffectiveness of its transmission, influencing how the participants appropriate information and use them to organize their thoughts and decisions regarding their self-care.

A study showed that, among the young, we identified a higher degree of knowledge related to HIV. However, in relation to the other STI's, the information were scarcer, mainly in relation to the curable IST's, such as Chlamydia, for example, signaling the importance of health professionals to pay more attention to other sexually transmitted diseases^[16].

Thus, it is mandatory to know the content of information about STI's disseminated by health professionals, the methodologies employed in this moment so essential that it is education in health, as well as the essence of the information of the group belong to these women. In attention to sexually transmitted diseases, it is of utmost importance that health professionals understand how women recover their prior knowledge, discuss, remake and implement them in everyday life, making behavioral choices outside the context of STI's. Health professionals should have the understanding that this dynamic has a direct relationship with each person, with the sources of information, educational and social level, as well as the material and human resources available for the process of education in health^[17].

The group explored in this study, when reflecting on their behavior against STI's, although demonstrate an understanding of the importance of protection against STI's, do not make it for a couple of reasons ranging from the belief that there is no need by being married, for having conducted the final sterilization procedure up to the fact that the imposition on the part of the partner does not use a condom. These beliefs are important barriers to the adoption of effective measures to prevent and combat the STI's, making these women more vulnerable.

The family context has special correlation with the vulnerability related to STI's, once that attitudes and personal behaviors are strongly influenced by beliefs rooted in the family and, especially, the male culture saturated in social practices in the scenario explored^[18].

In spite of women investigated are aware that the use of condoms is an essential measure for prevention of STI's, they abdicate this resource at the expense of the desire of the spouse not to use it, unable to establish an open dialog with their partner, thus showing their inability to expose their own wills and a consent with the situation. Thus, the results demonstrate the understanding that this situation of subordination of women to their spouses greatly influences their health condition, especially those aspects related to the prevention of STI's.

A survey signaled that 82% of women vulnerable can accept the suggestions of their sexual partners in any circumstance. Characteristics such as low educational level, limited awareness, dependency, reside in a needy area, family disintegration, feeling of inability and lack of support are among the factors those require to accept all the requests of their sexual partners. This issue, in that study, was more observed among the elderly^[15].

It is of essential importance that health professionals are aware of the relationship between the subordination perceived by women and the difficulty of implementing preventive measures to STI's in daily life and have the understanding that this construction is articulated in a historically and culturally woven web with meanings and values embodied in daily routines with an impact on the interactions of care, which may cause damage to health^[19].

When analyzing the contents exposed, there is the emergence of negative feelings and concerns related to both the experience with the IST, as well as the possibility of being infected. Living with an STI affects not only the physical dimension, but also the social and psychological dimension, requiring not only cognitive skills to handle the situation, but also emotional. The difficulties related to STI's are based on psychosocial content those require research and knowledge, once reflect in the decision-making of women, influencing on their exposure to STI's^[20].

In the context examined, it was possible to deduce the narratives of the participants a concern mainly related to dependence on others in the future ahead to the emergence of complications of an STI. Studies conducted with infected people showed that there are nonspecific concerns, but also concerns related to financial issues, especially when the people affected are aware that, in some cases, it is a condition in the long term. The concerns are also facing a recurrence of an STI already treated, afraid to transmit to other people and also for a neonate during a possible pregnancy^[21].

An search also showed that, in addition to the physical side effects, psychological changes may arise from the treatment of STI's, with psychological symptoms ranging from depression to fear, evoking feelings of shame and causing suffering even existential, demanding from the health team a stand turned to issues related to sexuality with strong technical-scientific foundation and with planning of care from the perspective of the woman assisted^[22].

In this research, we found that women, in addition to use therapies recommended by health services, also use culturally shared resources, such as medicinal herbs for the purpose of treatment, as well as prevention of STI's. A study shows the significant role that medicinal plants play in health care of women, with an impact on the reduction of mortality rates; however, warns about the importance of conducting more consistent research about the proof of the effectiveness of these herbs, as well as toxicological studies to analyze their safety. Thus, it is important to explore more systematic way the local perspectives on the use of medicinal plants applied to the treatment and prevention of STI's, in order to build knowledge on the traditional practices of health of the group explored^[23].

CONCLUSION AND FUTURE CONSIDERATIONS

Whereas the objective of this study, for women in the socio-cultural context explored, it was possible to identify the reasons and weaknesses to perform the treatment and prevention of STI's which are: the need to overcome and test their own limits are indicated as reasons for access to treatment and the inability to impose on her partner is signaled as a weakness to follow to preventive measures. It was identified that women indicate certain dissatisfaction with the knowledge they have and realize that they need more information.

Thus, it should be noted that health professionals should direct efforts to better support women within the context of the STI's, promoting an adequate sexual health advice, conducting aligned to the real expectations of these women with approaches to sexuality issues so broad and detailed. One should also consider that this woman is inserted in a context where issues relating to gender are still prevalent and make difficult the decision-making process in the perspective of her care.

From the perspective of prevention of STI's, it is of essential importance that the health team arouses reflections about the conscious involvement of the woman with care for her body, as well as during the completion of treatment, which can often be shrouded by discomforts, effects and doubts by the uncertainty of the outcome of the case, generating anxieties and concerns.

This research has brought even the reflection on the importance of conducting studies that take into consideration the woman while a social element, her experiences and the impacts of an STI in her everyday life, with the aim of exploring how these women think, act and the resources that this person has to deal with a disease so delicate and of overall risk, with a view to prevent its spread.

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