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Adolescents and young adults infected by the Human Papillomavirus (HPV): vulnerabilities and feelings experienced

Adolescentes y adultos jóvenes infectados por el Virus del Papiloma Humano (HPV): Vulnerabilidades y sentimientos experimentados

Adolescents and adults young people infected by Human PapillomaVirus (HPV): Vulnerabilities and feelings experienced

Maria Carolina Oliveira Reis[a]
Adenilda Lima Lopes Martins[a]
Rosely Cabral de Carvalho[a]
Rita de Cássia Rocha Moreira[a]
Marcelo Torres Peixoto[a]
Sandra Ely Barbosa de Souza[b]

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ABSTRACT

Objective: To know the vulnerabilities experienced by adolescents and young adults infected by the Human Papillomavirus attended at a reference center in Feira de Santana – Bahia.

Method: Qualitative study, carried out with a semi-structured interview with 20 adolescents and young adults, from November 2020 to February 2021. For data analysis, the Content Analysis proposed by Bardin and the software Iramuteq were used.

Results: The discovery of the infection highlights the misunderstanding about illness, fear, despair and guilt, individual and collective dimensions that point to little knowledge about the Human Papillomavirus.

Final considerations: It is necessary to implement public policies to minimize risks, through knowledge and confrontation of sexually transmitted infections, as well as health promotion strategies and shared decisions for the process of behavior change in adolescents and young adults.

Keywords: Papillomaviridae. Health vulnerability. Adolescent. Young adult.

RESUMO

Objetivo: Conhecer as vulnerabilidades vivenciadas por adolescentes e adultas jovens infectadas pelo Papilomavírus Humano atendidas em um centro de referência em Feira de Santana – Bahia.

Método: Estudo qualitativo, realizado entrevista semiestruturada com 20 adolescentes e adultas jovens, no período de novembro de 2020 a fevereiro de 2021. Para análise dos dados, utilizaram-se a Análise de Conteúdo proposta por Bardin e o *software* Iramuteq.

Resultados: A descoberta da infecção realça a incompreensão sobre o adoecimento, o medo, o desespero e a culpa, dimensões individuais e coletivas que apontam para o baixo conhecimento sobre o Papilomavírus Humano.

Considerações finais: Faz-se necessário a implementação de políticas públicas para minimizar os riscos, pelo conhecimento e enfrentamento às infecções sexualmente transmissíveis, bem como estratégias de promoção da saúde e decisões compartilhadas para o processo de mudança de comportamento em adolescentes e adultas jovens.

Palavras-chave: Papillomaviridae. Vulnerabilidade em saúde. Adolescente. Adulto jovem.

RESUMEN

Objetivo: Conocer las vulnerabilidades vividas por adolescentes y adultos jóvenes infectados por el Virus del Papiloma Humano atendidos en un centro de referencia en Feira de Santana – Bahia.

Método: Estudio cualitativo, realizado con entrevista semiestructurada a 20 adolescentes y adultos jóvenes, de noviembre de 2020 a febrero de 2021. Para el análisis de datos se utilizó el Análisis de Contenido propuesto por Bardin y el software Iramuteq.

Resultados: El descubrimiento de la infección destaca la incomprensión sobre la enfermedad, el miedo, la desesperación y la culpa, dimensiones individuales y colectivas que apuntan al bajo conocimiento sobre el Virus del Papiloma Humano.

Consideraciones finales: Es necesario implementar políticas públicas para la minimización de riesgos, a través del conocimiento y enfrentamiento de las infecciones de transmisión sexual, así como estrategias de promoción de la salud y decisiones compartidas para el proceso de cambio de comportamiento en adolescentes y adultos jóvenes.

Palabras clave: Papillomaviridae. Vulnerabilidad em salud. Adolescente. Adulto joven.

[a] Universidade Estadual de Feira de Santana (UEFS), Departamento de Saúde, Mestrado Profissional em Enfermagem. Feira de Santana, Bahia, Brasil.

[b] Universidade Federal da Bahia (UFBA), Departamento de Saúde. Salvador, Bahia, Brasil.

INTRODUCTION

Vulnerabilities are direct or indirect uncertainties and weaknesses that affect people in any stage of their lives[1]. Individuals and collectives have different levels of vulnerability to disease, as highlighted by early studies about vulnerabilities during the growth of investigations about the Human Immunodeficiency Virus (HIV). Considering this, our starting point to reflect on the health of adolescents and young adults infected by HPV was highlighting their social and cultural conditions as they acquired the disease[2].

HPV is the most common Sexually Transmitted Infections (STIs) and the main risk factor for cervical cancer (CC), the third most frequent type of cancer in women. Estimates indicate that, in 2021, there would be 16,710 cases, making it a serious public health issue[3]. Associated risk factors include: the early start of sexual activity, multiple partners, not using condoms, and, mainly, lack of immunization[4]. The presence of other STIs and skin integrity lesions also favor the entrance of the virus in the mucosa.

There is no recommendation for adolescents and young adults, that is, the group of women from 10 to 24 years old, to undergo yearly cytological exams. According with the Ministry of Health (MH), this age group has a high rate of spontaneous remission and the cancerous strains that cause the cell changes that underlie CC in healthy populations take from 10 to 20 years to develop. As a result, cytological exams start to be recommended from 25 to 64 years of age, during which period they should be carried out yearly until there are two negative exams, after which the interval increases to once every three years[5].

The term vulnerability, associated with the risks of HPV, allows us to translate the complexity of individual and collective aspects related to exposure in the health-disease process, in order to replace preconceived ideas that generate prejudice and stigma[6].

When adolescents and young adults are infected with HPV they are confronted with feelings of denial, fear, low self-esteem, prejudice and stigma in different levels, which are associated with a misunderstanding about the infection, which makes them vulnerable and makes the health-disease process more difficult to understand[6,7].

Understanding the vulnerabilities and presuppositions of collective health[2,8] in dimensions helps us understand this phenomenon. When considering the individual dimension, we can discover the knowledge that is present in an individual's reality; in the social dimension, this knowledge is related to access to information and to the capacity to intervene socially to guarantee safety and protection to one's health; in the programmatic dimension, we consider the access to health programs and services and their quality, and whether assistance is integral. These were the concepts that guided the study.

The discourse associated with safe sex reiterates the disease, the danger, and the guilt, with a moralist and prescriptive tone that leads to silence and difficulties forming a social identity[9]. Gender issues in sexuality increase risks to health in multiple dimensions, and feelings experienced after infection may difficult accepting the treatment[6].

To analyze social vulnerability, it is essential to understand the access these women have to information, which can come from school, family means of communication, and health workers, so protective practices can be considered and constructed[9,10]. Considering the complexity of this, especially during adolescence, it is paramount to invest in teaching, assistance, and in the management of health care through the knowledge about the clinic of the disease and its treatment[11], considering the vulnerabilities and preventive actions in this stage of life.

Based on these arguments and on the understanding that there must be scientific progress in the field of HPV vulnerabilities, this study was guided by the following guiding question: what are the situations of vulnerability and the experiences of adolescents and young adults infected by HPV?

The goal of this study was to understand the vulnerabilities experienced by adolescents and young adults infected by HPV and attended in a referral center in the city of Feira de Santana, in the state of Bahia, Brazil. Therefore, we expect to contribute to prevention strategies in this age group and to embrace and educate in order to generate health promotion, leading to reflections that can encourage preventive and self-care measures.

METHODOLOGY

This is a qualitative and exploratory study, created according with the 32 items of the *Consolidated Criteria for Reporting Qualitative Research* (COREQ), a tool to improve the writing of qualitative studies. The study included 20 adolescents and young adults diagnosed with HPV who were in accordance with the following inclusion criteria: adolescents and young adults sent to the referral service with suspected or diagnosed HPV infections. Adolescents and young adults with difficulties speaking that prevented data collection were excluded.

The number of participants was determined by the theoretical empirical data saturation, that is, when it became impossible to reach new discussions by collection more data, the collection was stopped, as it would not be necessary for more young adults to answer to the data collection

instrument. To reach saturation, three researchers carried out independent early analyses of data, to redefine the meaning nuclei that emerged from the data collected. After there was an agreement between two researchers, data collection was considered complete.

The field of the empirical investigation was a Referral Center in the city of Feira de Santana, in Bahia, founded in 2004. The activities developed in this setting include medium complexity services, from the screening to the treatment of HPV infections. Collection took place from November 2020 to February 2021. The research included 20 women. The women were selected intentionally: scheduled patients who were waiting for attention at the service and had a confirmed HPV infection diagnosis.

To access the participants, strategies such as embracing and qualified listening were used by the nurse who works in the service and main researcher. These strategies of care are recommended by the National Humanization Policy (NHP), which proposes establishing forms to embrace and include users in the attention through therapeutic actions and articulation with the multiprofessional team, to provide access and attend to the needs of the service[12].

At this time, they were invited to participate in the research and the objectives, goals, risks, and benefits of the investigation were presented to them. When the patient was a minor, their tutors also received explanation and guidance. As they accepted participation, they were asked to sign the Free and Informed Consent Form (FICF) and the Free and Informed Agreement Form (FIAF), to confirm their acceptance.

The interviews took place in a separate room in the presence of the researcher and the interviewee, with a mean duration of 40 minutes and application of a semistructured instrument previously elaborated and validated by two professors/researchers from the research group who were specialized in the field.

The instrument included the sociodemographic and individual characterization of each participant, and its research questions were: What do you know about HPV? Did you consider yourself a person with chances to be infected by an STI? How did your life change after you discovered you had HPV? After these questions, the interviewee also instigated the participants to express more using requests such as "Tell me more about how it happened" and "Tell me more about this situation", in order to give substance to the phenomenon under investigation.

After the interviews, all doubts of patients were clarified. Their questions about the transmission and treatment of HPV were answered in a clear and objective way, to advise them on how to care more consciously for their health.

Data was recorded digitally and later transcribed into Word documents. Participants' names were replaced by codenames, using the letter A (for Adolescents/young Adults), followed by the corresponding interview number (A1, A2... A20). Four pilot interviews were carried out for researchers to validate and become familiar with the instrument. Only after that collection started. There was no need to repeat the interview, and no participant refused or abandoned the research.

Later, data were organized and analyzed according with Bardin's Content Analysis Technique, which allowed for the identification of nuclei of meaning and key-expressions, the classification of similarities, and the description of differences that represented the collectivity of the research[13]. All data collected and analysis carried out will be stored by the main researcher for five years.

The analysis was carried out by the main researcher, starting with the identification and grouping of the extracts of individual responses that addressed the knowledge of participants about HPV and the impact of the diagnoses on them, without grouping the 20 texts. Then, each text was treated to become part of the corpus of the research and be processed by Iramuteq, version 0.7 alpha 2. This stage included the suppression of grammatical symbols, the editing of abbreviations or acronyms, and the standardization of words, so the orthographical and grammatical norms of Portuguese were respected.

To continue the analysis, the corpus was submitted to a lexical analysis, explored using Reinert's method and a similitude analysis. The product of the lexical analysis is the descending hierarchical analysis (DHA), which analyses the frequency of words in the corpus and whether there is a significance association between them according with a p value of $p \leq 0.001$. Starting then, the software uses the chi-squared (x^2) test to verify the association between words of a specific class, grouping them according with their significance. The similitude analysis uses lemmatization to identify the relationship between the words mentioned, generating a tree-chart where the most frequent words form nuclei from which sub-frequent words branch, that is, words that have a connection in the reports[14].

After the classes were formed by the software, the text segments from each class were accessed their respective titles elaborated. These results were analyzed considering similarities between them and the categories of content analysis[13], leading to the finding of four categories of analysis. The results were interpreted according with the theoretical framework on vulnerability.

Regarding ethical aspects, the study was approved by the Research Ethics Committee at the Universidade Estadual de Feira de Santana, under protocol 3.965.883 (CAAE 26306719.2.0000.0053), respecting all the principles of autonomy and responsibility according with Resolutions 466/12 and 510/16 from the National Council of Health.

RESULTS AND DISCUSSION

According with their sociodemographic profile, these adolescents and young adults were mostly students, and self-declare as brown. Their family income was lower than one minimum wage and their educational level was complete high school. Their first sexual intercourse took place between 13 and 18 years old, in most case at 15. Regarding their number of sexual partners, they mentioned from one to seven, with most participants stating to have two. Although most of them did not have a religion, they evoke the presence of God in their statements.

Participants stated to be heterosexual, but some reported having had sexual intercourse with both men and women, indicating that, in this age group, they are still forming their sexual identity. Most participants had been immunized for HPV. However, some of them reported that they were immunized after the infection was diagnosed.

The profile of the adolescents and young adults interviewed was indicative of lower educational level and higher risk for HPV. Most of them had a low educational level and poor socioeconomic conditions. These characteristics justify their little access to information about HPV, as well as the risk for vulnerability in the population analyzed.

Therefore, it is essential to understand the biopsychosocial environment where these adolescents and young adults are inserted, in addition to evaluating their social and cultural contexts and the influences from family, friends, school, and professors in the construction of their identity.

According with the analysis by the descending hierarchical analysis, as generated by the software Iramuteq,5,161 words were found, with 626 unique words forming 20 corpora that included 151 text segments. From these, 125 segments were used, whose mean frequency was 82.78%.

From the total number of words found and matched with text segments, indicating a similarity, five Classes of words were found: Class 1 – Programmatic actions in health; Class 2 – Search for knowledge, prevention; Class 3 – Discovering the disease, the risk of infection, and the feelings experienced after the infection; and Class 4 – Accessing and sharing knowledge: recognizing oneself as vulnerable. Classes 1 and 2 have a common axis, and, as such, will be analyzed together under the topic Barriers to the access to prevention. The data associated with this hierarchy are described in Figure 1.

In Figure 1, the four Classes of words mentioned in the texts are distributed, as well as the percentage of citation of each Class. Notably, Class for is more distant from the other classes as it represents sexuality and recognizing vulnerabilities. All other Classes have a common axis. There is an intersection between Classes 1,2, and 3 in regard to the disease and preventive actions.

The classes of words generated by the software Iramuteq allowed three empirical categories to be determined. They will be discussed below according with the theoretical framework of Bardin's content analysis[13].

Discovering the disease, the risk of infection, and the feelings experienced after infection

During the first moments after the diagnosis of STI, fear stands out. It implies in recognizing the multiple dimensions affected by discovering the infection: the risks, uncertainties, and misunderstandings about the disease, which favors false thoughts, and opens space for taboos[6].

Statements showed the meaning of the vulnerabilities and how the state of being infected by the virus impacts on the feelings experienced: fear, despair, and guilt were the most common.

> (A7) *When I found out, I got desperate* [...] *That it's a disease that's getting common and a lot of people have.*
>
> (A8) *When I found out I got really upset, I started sobbing* [...] *a feeling of guilt.*
>
> (A14) [...] *but I'm afraid. I thought there will be no cure, that I would not be able to treat it* [...].

The discovery, the first impact of the disease, has an emotional demand. If it is not well handled, with therapeutic strategies, it can become worse and influence the daily life of the patient. This feeling of guilt and fear is a breeding ground for emotional stress, changing one's self-image, giving strength to taboos and predisposing women to depressive states[4].

It can be noticed that these women associate the HPV infection with the fear of developing CC. In association with this feeling, they feel guilt due to the fact that they did not care for themselves as they could have:

> (A11) [...] *that we discover, we go to the Internet to see, and soon, I will die, because this is there, that it will become cancer, that the HPV is the main reason for cervical cancer*

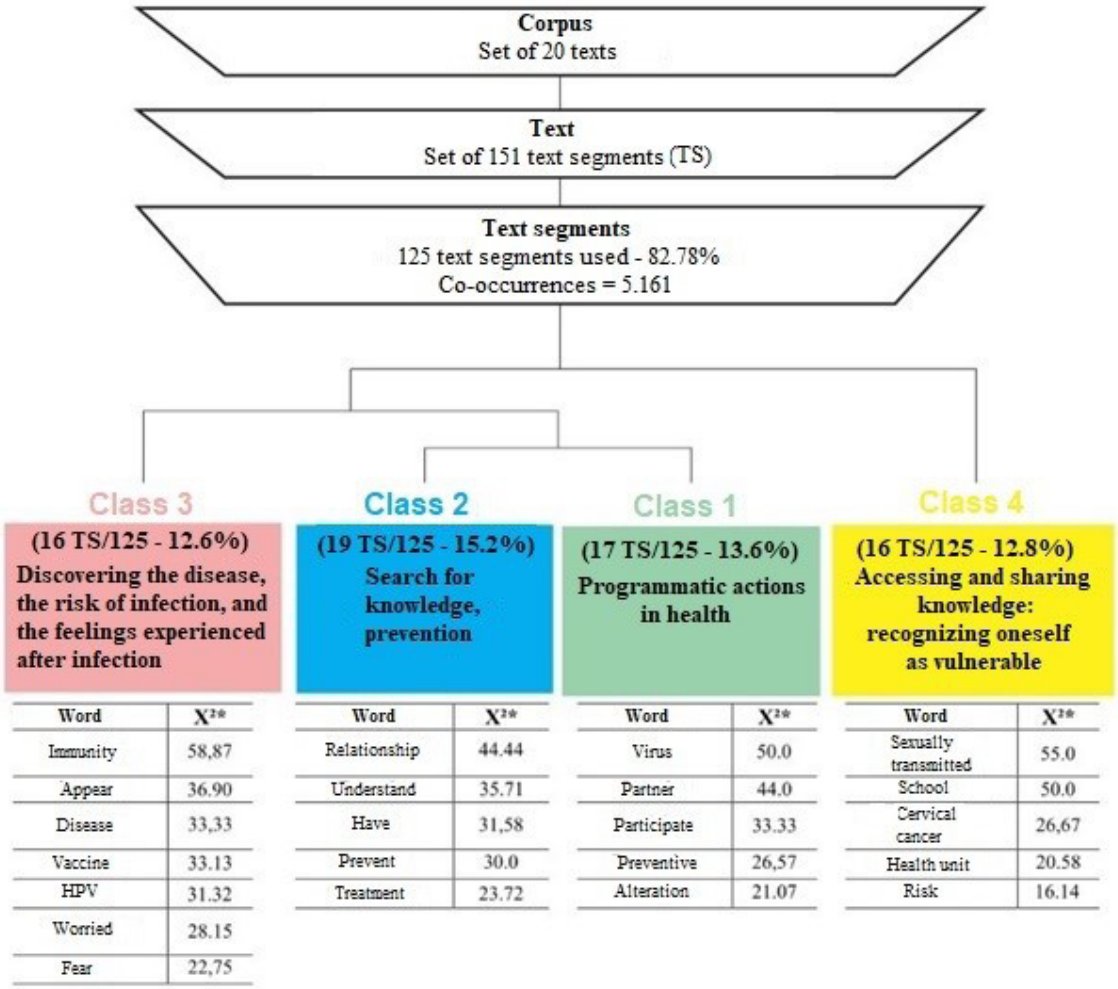

Figure 1 – Dendrogram of the descending hierarchical analysis with the classes of words generated in the research. Feira de Santana, Bahia, Brazil, 2020-2021
Source: Research data, 2020-2021.

cases. I imagined a lot of stuff, that I'll have to remove my uterus, that I wouldn't be able to have a child.

(A3) [...] *it was really impacting, because I didn't expect it* [...] *it's really frightening.*

(A14) *I became afraid, a bit guilty too, because I didn't care for myself and* [...] *very afraid, I mean, of dying, of it being something worse.*

The discourse in the relationship between HPV infections and the fear of developing CC in the diagnosis and treatment when infected, considering the little quality of the information, increase the odds of actions that could bring harm to the health of the patient and even of the partner. It should also be mentioned that there is an important gap in researches involving adolescents, sexuality, knowledge about the HPV virus, and its repercussions on women's health.

Sexuality is a topic seldom discussed by society. Educational actions in this regard are repressed since childhood, leading to issues that become increasingly "tangled". Adolescents are afraid of talking to their parents about their affective relationships, which leads to issues in having open conversations that could clarify their doubts and lead to positive experiences within the family[15].

The information that adolescent and young adult women have about HPV are still restricted. This reiterates the need of primary prevention and screening for precursor lesions, the encouragement of condom use and the administration of the vaccine against HPV.

(A17) *I thought, I had this thought, that I took the vaccine, so there's no chance I'll get it.*

(A5) [...] *I was vaccinated only after I found I already had HPV* [...].

Most have knowledge about the vaccine, but this knowledge is incomplete and was acquired late. Some women in this study only received information on the vaccine after the infection, which provides them with partial immunity.

The other forms of prevention should continue to be encouraged. The use of condoms, for example, should continue after the vaccine is used. Not using it may lead to infections by other types of HPV or other STIs. Furthermore, secondary prevention through cytological exams must be carried out to screen for precursor lesions, according with MH recommendations.

The similitude tree (Figure 2), elaborated by the software Iramuteq, reiterates the representation of the discovery of HPV. The adolescents and young adults describe their understanding about sexually transmitted infections. The terms disease, sexually transmitted, and condom appear the nearest to the center of the similitude tree. The word school is distant from the expression health unit, showing the need for a greater articulation between primary care and school and showing how important it is to promote, through a health education program at school, a space for education in health. The word "partner" is close to the words condom and fear, showing that these adolescents and young adults are vulnerable in their relationship.

Accessing and sharing knowledge: recognizing oneself as vulnerable

The discovery of the infection and its first impact lead patients to recognize their vulnerability. Individual vulnerability starts with concerns regarding the infection and the possibility of generating protective practices using this information[1,6].

(A12) *I got scared in this case, because of how probable it was that I had it. Scared and frightened, afraid that I could harm my health, thinking about the people and the family and how concerned they would be too.*

(A14) [...] *also, I was thinking about our financial situation, my family's, without knowing how much a treatment cost would, I'd need it every day, every month.*

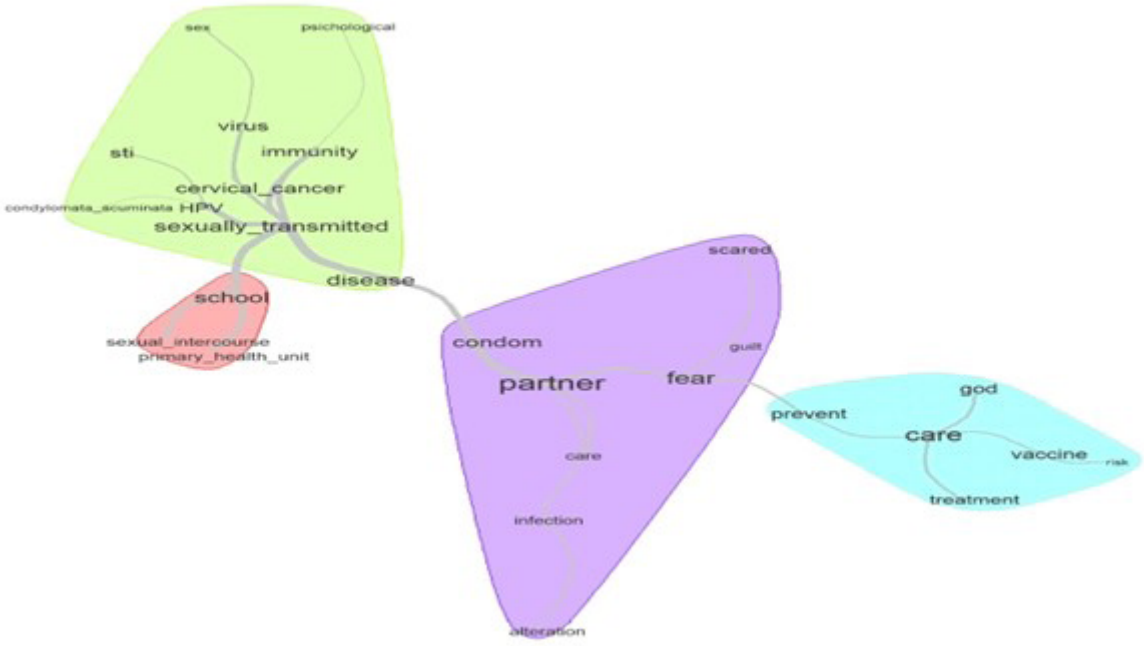

Figure 2 – Similitude tree elaborated using the Iramuteq software. Feira de Santana, Bahia, Brazil, 2020-2021
Source: Research data, 2020-2021.

The statements of the women show their preoccupation with their family with how their relatives would receive the news of the diagnosis, the repercussions of the disease, among which the preoccupation with the cost and length of the treatment.

In these statements, it is possible to notice that trust in partners and stable relationships lead them to use the condom rarely or never, with the expression of social constructions associated with the hegemony of men in gender relations[10].

(A8) *But I believe I'm not as vulnerable because I am married and only have one partner, you see?*

(A14) [...] *I think I'm probably wrong in thinking this way, but since I have a stable relationship... but really, having a stable relationship does not mean I don't have to use, right, for prevention* [...].

However, when the HPV diagnosed is confirmed, questions, ambiguous feelings, and a search for the guilty party start. A distorted perspective due to the little quality of the information these women have led to risk behavior that were not perceived and understood as potentially leading to an infection.

(A11) [...] *we think, you know, that it only happens with someone else, with those people who have a bunch of sexual partners* [...].

(A7) [...] *then, I kept asking myself: Where did it come from? Because, in a way, he was also infected and we didn't know where it came from, from me or from him.*

(A11) [...] *actually, I think I got it from my partner, because he was the only person I had unprotected sex with* [...].

The idea of holding the partner accountable for the contamination must be deconstructed. One cannot know the exact moment of contamination, since this is a highly prevalent asymptomatic disease, which makes it difficult to identify when it was acquired. What is important is diagnosing it and treating any of its clinical manifestations.

When asked about where they acquired knowledge about sexuality and sexually transmitted infections, most describe school and the Internet as their main sources of information on the topic.

(A11) *I learned it at school* [...] *on the Internet, TV, means of communication. My relatives never talked about it* [...] *about sex, and even less about STIs. I think there's a lot of taboo, a lot of prejudice. Even today, after I got this virus, I barely speak with my mother about it.*

(A3) [...] *at university and on the Internet, but at home we've never talked much about it.*

Only two participants mentioned their family as a source of knowledge about STIs:

(A14) *At home it's very rare to talk about the subject, because, I mean, it's just my mom, you know?*

(A8) *My mom, because she's a nursing technician, and she always, always insisted on that. Ever since she knew, she always gave me advice.*

Considering this information, we can see the difficulties in discussing one's sexuality in the family environment and, consequently, this weakness in the knowledge about STI. Minimizing the vulnerabilities and breaking the barriers that prevent embracing and dialog so sexuality can be addressed with less prejudice in order to construct knowledge and develop protective practices is essential to receive information adequately, be it from school, family, or from health services[10].

Insufficient knowledge, associated with family nuclei where there is no space for dialog, leads to social vulnerability. In this stage of the life of adolescent and young adult women, when they are going through transformations and forming their identities, it is necessary to strengthen knowledge to form the bases for decision making[10].

Although the infection of these patients was confirmed, most sexual partners continue to expose themselves to risky behavior. When asked about their use of condoms, they report:

(A7) *He complains a lot* [...] *But I want to use it. I feel protected. I argue with him. He says it, but it's bad* [...].

(A11) *A lot, he doesn't like it. Not only him. Other partners I had in the past have a lot of resistance. They don't like it.*

The resistance to using condoms makes the control of the infection more difficult as it leads to frequent exposure. Almost all women report that the men are more resistant to the use. Gender roles are, frequently, hierarchical. This makes it difficult for women to negotiate the use of condoms. These power relationships are asymmetric, and these unequal relationships prejudice from the negotiation of safe sex to accusations caused by the fact that the disease was acquired. It stands out that this inequality leads to the submission and reduction of women. This causes a vulnerability for the contraction of STIs[16].

Barriers to the access to prevention

Being infected by HPV generally leads to clinical lesions, known as condylomata acuminata, which is the most frequent manifestation of the virus. This is what leads the adolescent and young adult women to seek for the health services.

The lack of health self-care is associated with the lack of knowledge or to limited knowledge about the pathology. After the infection is diagnosed, they seek information to treat and prevent the pathology, as shown in the statements of some women:

> (A11) [...] *It's a virus, right? I forgot the scientific name, it's acquired in girls, ever since they start sexual activities* [...].
>
> (17) *I didn't know a lot until a got it, right? So, I tried to learn more I know it's a sexually transmitted disease* [...].

Preventive exams in primary health units with or without Family Health Strategies aim mostly to screen for the lesions to start early treatment. It is also a good moment to raise the awareness of these women about the need to practice self-care, encourage regular exams, condom use, and check vaccination.

The diagnosis of the infection encourages the search for more qualified information and, with the health workers, subsidies to treat and prevent recurring health issues. After the knowledge is acquired, they can understand the risks of exposure, which may lead to new behavior.

> (A16) [...] *but, I hadn't done it in four years. Now, I go for the preventive exams every year. Now, that there was an alteration, I'll start doing it regularly*
>
> (A11) [...] *I had to go through a more serious treatment because the virus was, I mean, more advanced. Then, it was when I started really caring, doing my exams, only then I understood how important they are.*

Knowing the disease etiology, transmission, and the ways in which it presents itself is essential to create behavior that minimizes risks and vulnerabilities and allows to confront the issue in both personal and social dimensions. The shared construction of knowledge leads to autonomy and empowerment, which are part of the theoretical framework of vulnerability[17].

In addition to universal access to health services, it is also necessary to strengthen the Primary Health Care, as a guarantee that adolescent and young adult women will be listened too properly. Considering the characteristics of this group of the population who does not have a routine of care, they seek for the service as a health demand that needs to be solved. Embracing them and providing them with qualified listening and health education is essential for them to understand how necessary it is to have a routine of care, which aids in the construction of bonds despite the diversity and uniqueness of each meeting between those who give care and those who receive it[18].

Programmatic actions in health, despite being extremely relevant, are still insufficient when we consider the participation of these women in preventive actions of health in the health unit of their neighborhood:

> (A2) *Yes, I did. When I was pregnant, I participated* [...].

It is essential to train professionals in order to improve health care practices and provide women with a type of attention that can attend to their demands and make them understand the importance of health care practices. Therapeutic strategies should provide those who experience the process with knowledge and the capacity to reflect. One must know personal, social, and programmatic conditions, as well as their influence as facilitators or hindrances in the process of health-disease. To promote health care actions, one must be aware of the health issue, search for help facing this issue, and open spaces to dialog with the family and with people in the same situation.

FINAL CONSIDERATIONS

Individual vulnerabilities related with sexuality, emotions, gaps in knowledge, and gender differences, directly influence social and programmatic dimensions.

This study allowed for an identification of states of vulnerability in the health-disease process, in addition to showing the changes in the perception about life cycles, thus contributing to plan care strategies articulated to public policies.

In this context, the risks and vulnerabilities perceived, the low level of HPV knowledge, and the existence of unsafe sexual practices make health education practices more challenging. These are paramount in the individual and social spaces of the family, in groups and at school, to develop the autonomy in adolescent and young adult women, so they can perform the role of protagonists of their health with a critical and sensible behavior.

The experience of spaces of dialog among adolescents, young adults, teachers, health workers, and the community, especially in territories with Family Health Units, it is essential to use strategies, a social response to minimize situations of risk through the use of knowledge, as well as to share decisions and responsibility in order to bring into effect articulated strategies of care and public policies.

A potential limitation of this research is the fact it was carried out in a single setting that describes one specific context. Other scientific evidence may be found in other contexts. We recommend the replication of this research in distinct settings, since vulnerabilities are complex phenomena, especially in the case of adolescent and young adult women.

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Authorship contributions:

Formal analysis: Maria Carolina Oliveira Reis, Rita de Cássia Rocha Moreira.
Concept: Maria Carolina Oliveira Reis, Rosely Cabral de Carvalho, Adenilda Lima Lopes Martins.
Data selection: Maria Carolina Oliveira Reis, Rosely Cabral de Carvalho, Adenilda Lima Lopes Martins.
Writing – original draft: Maria Carolina Oliveira Reis.
Writing – revision and editing: Maria Carolina Oliveira Reis, Rosely Cabral de Carvalho, Adenilda Lima Lopes Martins.
Investigation: Maria Carolina Oliveira Reis.
Methodology: Maria Carolina Oliveira Reis, Rosely Cabral de Carvalho.
Resources: Maria Carolina Oliveira Reis.
Software: Maria Carolina Oliveira Reis, Marcelo Torres Peixoto.
Supervision: Rosely Cabral de Carvalho, Adenilda Lima Lopes Martins.
Validation: Rosely Cabral de Carvalho, Adenilda Lima Lopes Martins, Sandra Ely Barbosa de Souza, Rita de Cássia Rocha Moreira.
Visualization: Maria Carolina Oliveira Reis, Rosely Cabral de Carvalho, Adenilda Lima Lopes Martins, Sandra Ely Barbosa de Souza, Rita de Cássia Rocha Moreira.

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Corresponding author:

Maria Carolina Oliveira Reis.
E-mail: carolinareisenfa@gmail.com

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