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Behaviors related to sexual health of people living with the Human Immunodeficiency Virus

Comportamentos relacionados à saúde sexual de pessoas vivendo com o Vírus da Imunodeficiência Humana

Conductas relacionadas con la salud sexual de personas con Virus de Inmunodeficiencia Humana

Géssyca Cavalcante de Melo[1]
Maria Cristina Soares Figueiredo Trezza[1]
Renata Karina Reis[2]
Débora de Souza Santos[1]
Jorge Luis de Souza Riscado[1]
Joséte Luzia Leite[3]

1. Universidade Federal de Alagoas. Maceió, AL, Brazil.
2. Universidade de São Paulo. Ribeirão Preto, SP, Brazil.
3. Universidade Federal do Estado do Rio de Janeiro. Rio de Janeiro, RJ, Brazil.

Abstract

Objective: To analyze the behaviors related to sexual health of people living with the Human Immunodeficiency Virus (HIV) according to the health promotion model. Specific aims: to identify the individual characteristics and behaviors of the subjects previous to the time of the survey; describe the feelings, self-efficacy, barriers, benefits and personal influences in relation to important behaviors to be modified; build an agreed plan of action together with the individual in relation to their behavior. **Methods:** This is a qualitative study held in 2014 with 14 participants through semi-structured interview in a specialized health service in Maceió-Alagoas. Pender's model was used as theoretical and methodological framework. **Results:** Four categories pointed to changes in the sexual-affective-relational life of the subjects: the use or non-use of condoms in sexual relations and the responsibility related to themselves and to each other; suspension/restriction of sex life and lack of romantic relationships; the gender, the power relationships and the sexual health of women with HIV; the strengthening of sex life and relationship affection. **Conclusion:** Seropositivity proved to be a situation in which behaviors are rethought; however the behavioral change desires arise pervaded by the stigma and the lack of support for decision-making. This study showed the model applied as another useful tool for nurses and other professionals.

Keywords: Sexual Health; Health Promotion; Health Behavior; HIV; Nursing theory.

Resumo

Objetivo: Analisar os comportamentos relacionados à saúde sexual de pessoas com Vírus da Imunodeficiência Humana (HIV) segundo o modelo de promoção da saúde. Objetivos específicos: Identificar as características individuais e comportamentos da saúde sexual dos participantes, prévios à pesquisa; descrever sentimentos, autoeficácia, barreiras, benefícios e influências em relação aos comportamentos importantes de ser modificados; construir um plano de ação acordado com o indivíduo em relação aos comportamentos. **Métodos:** Estudo qualitativo realizado em 2014 com 14 pessoas por meio de entrevista semiestruturada em um serviço especializado de Maceió/AL. O Modelo de Pender foi utilizado como referencial teórico-metodológico. **Resultados:** Quatro categorias apontaram aspectos comportamentais sexuais-afetivos-relacionais - o (não) uso do preservativo nas relações sexuais e a responsabilidade voltada para si e para o outro; a suspensão/restrição da vida sexual e a ausência de relacionamentos afetivos; o gênero, as relações de poder e a saúde sexual de mulheres com HIV; o fortalecimento da vida sexual e do afeto relacional. **Conclusão:** A soropositividade se mostrou como uma situação em que comportamentos são repensados; contudo os desejos de mudança comportamental aparecem permeados pelo estigma e pela falta de apoio para a tomada de decisões. Este estudo sinaliza o modelo aplicado como mais uma ferramenta útil para enfermeiros e demais profissionais.

Palavras-chave: Saúde Sexual; Promoção da Saúde; Comportamentos de Saúde; HIV; Teoria de Enfermagem.

Resumen

Objetivo: Analizar las conductas relacionadas con la salud sexual de personas con VIH de acuerdo con el Modelo de Promoción de la Salud. Objetivos específicos: Identificar características y comportamientos anterior de los sujetos; describir sentimientos, autoeficacia, barreras, beneficios y influencias relacionadas con comportamientos importantes para ser modificados; construir un plan de acción acordado con el individuo en estas conductas. **Métodos:** Estudio cualitativo realizado em 2014 con 14 participantes através de entrevista semi-estructurada en una clínica especializada en Maceió/AL. El Modelo de Pender se utilizó como marco teórico-metodológico. **Resultados:** Cuatro categorías se señalaron los cambios en la vida sexual-afectiva-relacional de los sujetos: El uso (no) de preservativos durante las relaciones sexuales y la responsabilidad por sí mismos y a otros; La suspensión/restricción de la vida sexual y la falta de relaciones sentimentales; Géneros, relaciones de poder y la salud sexual de las mujeres con VIH; El fortalecimiento de la vida sexual y afecto relacional. **Conclusión:** La seropositividad parecía mostrar cómo situación en que se reconsideran comportamientos, sin embargo, los deseos de cambio de comportamiento aparecen permeado por estigma y falta de apoyo para toma de decisiones. Este estudio indica el modelo aplicado como una herramienta útil para enfermeras y otros profesionales.

Palabras clave: Salud sexual; Promoción de la salud; Conductas saludables; VIH; Teoría de enfermería.

Corresponding Author:
Géssyca Cavalcante de Melo.
E-mail: gessycamelo@hotmail.com

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INTRODUCTION

The availability of resources increasingly improved for the treatment of the infection by the Human Immunodeficiency Virus (HIV) diverts the physical death of the path of the affected people, enabling them to return to a practically normal sexual life, at least from the organic point of view. In other words, the genital anatomy of individuals remain healthy, as well as other bodily functions, implying the possibility of rebuilding life projects and emotional relationships, whether they are HIV-concordant or HIV-discordant[1,2].

However, there are situations in which the sexual health of people living with HIV still remains compromised by their meanings, since the virus is not eliminated from the body. Thus, it may not have been appropriate for some individuals to return to the wanted sexual normality that is characterized by the possession of all the attributes that allow individuals full interaction with others and the experience of an informed, enjoyable and riskless life[1,3].

In this respect, it is crucial that health services assume the role of privileged spaces so that different ways of coping with these disabilities are included in their routine. This way, people with HIV may keep an affective and sexual relationship, if they so choose[4]. Therefore, it is important that the approach to sexuality does not occur in a generalized way, restricted to prescriptive guidance, as if people were matched by the same practices, as it commonly occurs in prevention campaigns[5].

According to the logic of the health promotion paradigm, this exercise is not easy to be executed, as it means that professionals should include systematic investigation routines of the most intimate and silent needs of individual in their daily work, seeking the construction of shared knowledge, based on their value judgments in terms of behavior and the ability of individual choice and mediation between the people and their environment[6].

In the nursing field, the number of studies that seek to highlight the importance of using theories that facilitate the understanding of the determinants of health and guidance solutions that meet the needs of people is increasing[7]. Among these theories, there is the Health Promotion Model (HPM) developed by the nurse Nola Pender as an integration of the perspectives of nursing and behavioral science to address the biopsychosocial processes that influence individuals to adopt healthy behaviors[8].

The HPM provides a diagram composed of a clear taxonomy that encompasses behaviors that promote individual or group health, allowing planning, intervention and evaluation of their actions by studying the relationship of three components: 1) Individual characteristics and experiences involving the previous conduct relating to behavior and personal factors that lead a person to adopt a certain behavior; 2) Feelings and knowledge in terms of behaviors that need to be modified and the desired objective in relation to them, which are modifiable variables, whose changes may depend on motivations that are originated in health professional actions and which involve people's beliefs in terms of benefits, barriers, self-efficacy and influences to modify their behavior; 3) Desirable health promoting behavior, namely the action directed to positive health outcomes[8].

In the context of HIV, the multidisciplinary team needs to add to its performance not only knowledge in terms of the disease, but also the expanded concept of health, in order to fully identify ways of living that influence the well-being of individuals, including in the sexual health field. This study has the main objective of analyzing the behaviors related to the sexual health of people living with HIV according to the HPM.

The specific objectives include identifying the individual characteristics and behaviors related to the sexual health of the subjects, previous to the time of the survey; describe their feelings, self-efficacy, barriers, benefits and influences in relation to the behaviors that need to be modified and build an action plan agreed with the individuals regarding their behavior.

METHODS

This is a cross-sectional and qualitative study, using HPM as a theoretical and methodological framework. This model includes the commitment to an action plan that should be built jointly between users and health care professionals, because even if they aimed at a common goal, both interpret each situation in its own way.

Thus, the nursing meta-paradigm established for the HPM was designed by Pender by means of the following concepts: 1) Person: biopsychosocial organism partially shaped by the environment, but which seeks to create it in such a way that the inherent and acquired human potential can be expressed; 2) Environment: physical-sociocultural context in which life develops that can be manipulated by the individual to create signs that facilitate health producing behaviors; 3) Nursing: collaboration with individuals, families and communities to create more favorable conditions with a view to expressing high levels of well-being; 4) Health: life experience in evolution[8].

The interviews were based on the concepts and diagram of the HPM[8], and were performed on an HIV specialized outpatient clinic linked to the Municipal Health Secretariat of Maceió, Alagoas, Brazil, between June and November 2014, through a semi-structured form with the following guiding question: Tell me how your behavior was related to your sexuality before the diagnosis of HIV and how this behavior occurs in the present moment. After identifying the behaviors, participants were led to reflect and rethink experiences from issues related to their desires for change, benefits, barriers, feelings and perceived influences. The study included 14 people who had knowledge of the diagnosis of HIV/AIDS for a time equal to or shorter than one year, they were over 18 years of age and presented clinical conditions at the time of the production of the information.

After the transcription of the audio, a dense material was collected in the speeches of the subjects. As similar phenomena, represented in context units, were analyzed from the perspective of the assumptions of the HPM[8], they were grouped. Through an inductive process, categories that are relate to behaviors that can

influence the sexual health of the person with AIDS were found. Then, participants were contacted for a second meeting, so that the construction of a joint action plan to promote sexual health was initiated from their own needs, wants and conditions to achieve it.

The project was approved by the Research Ethics Committee in 2013 (Process Nº 17668013.5.0000.5013) by Plataforma Brazil, obeying what is recommended in the Resolution of the National Health Council No. 466 of 2012. Participants signed a consent form, and the results were referred to by alphanumeric codes to preserve their identity.

RESULTS AND DISCUSSION

Among the 14 participants, ten were male and four female. They were between 20 and 70 years, and the most represented age group was from 20 to 29 years (n = 5), followed by 40 to 49 years (n = 4). As to marital status, singles have prevailed (n = 10). The level of education varied from low to medium and the highlights were illiterate individuals (n = 2), people with incomplete primary education (n = 5) and complete (n = 3), and high school level (n = 2). As for the occupation, two were retired, three found themselves unemployed because of health problems resulting from HIV, two were housewives and seven had some type of job. On sexual orientation, the highlights were the subjects who reported themselves as heterosexual (n = 7) and homosexual (n = 4).

The exercise of bringing behaviors related to sexual health with the taxonomic structure of HPM, along with the components that comprise it, has allowed the dimensions and contexts in which they occur in the reality of the person with HIV to be seen. After thorough analysis of the speeches four categories have emerged.

Category 1 - The use or non-use of condoms during sexual intercourse and the responsibility related to themselves and to each other

Among the behaviors surveyed in matters of sexuality, it was noticeable that the theme related to "genitality" and sexual intercourse appeared as one of the elements present in the interviews, seeming to show a linked sexual expression to a greater importance given to certain preventive practices, as was found in another study[9]. This fact is part of the dominant thinking on the subject in the area of HIV, causing difficulty in opening space for other meanings related to sexual health.

However, there is no denying that the reports on the practice of non-use of condoms in relationships (none of the participants referred to the female condoms) have direct implications for the promotion of sexual health of individuals, as can be noted:

> *Well, we did not use [condoms]. Because if we did, I think I would not be in this situation ... (P14, male, 20 years)*
>
> *Sometimes I use condoms, but he also has HIV. (P10, male, 21 years)*

From the reports of this research, participants were questioned about their views on the behavior and their views on a possible change of habit expressed, that is, on the use of condoms in all sexual relations. This exercise of listening to what individuals thinks in terms of their actions in life allows the opening of a space for users as true subjects, not as objects of intervention[6,8].

According to the HPM logic, the perceived benefits for the modifier action of habit are the positive mental representations that reinforce the consequences of adopting the behavior[8]. In this case, participants pointed out as the benefits of condom use in all relations not only the responsibility focused on oneself, but also on the others:

> *There is no other because one can have a viral load higher than mine and vice versa, right? (P9, female, 50 years)*
>
> *Because it is like I said, right? What I don't want to myself, what I got, I will not pass on to other. (P6, male, 35 years)*

It is possible to notice that the participants seem to be aware in terms of the importance of condom use. More than that, it is clear that they admit that safer sex can establish a responsible attention not only with the partners, but also with themselves. This consideration reinforces the idea that people with HIV may be more worried in terms of health, which can be characterized as a reflection of the infection treatment breakthrough due to its chronicity and hence the focus that receives most of the actions and research in the healthcare sector. Until the early 90s, most studies and preventive campaigns were directed, in a restricted manner, to the cessation of transmission, with a tendency to blame individuals with HIV, as if the subjects were to become asexual or had to exclude the sexual and emotional relationships from their life projects[2,9].

Perceived barriers to condom use represent the difficulties visualized for adopting such behavior[8]. This difficulty was identified by participants as the non-practicality in terms of the way of using it; the fact it is not a habit/common practice and the issue of personal taste:

> *I have difficulty with the condom [...] you have to take off the air, or else it will burst, as it happened last time. (P8, male, 46 years)*
>
> *Do you feel any difference? Feel it? Because when the person's not used to something... he/she will have to get used to it, you know? (P11, male, 70 years)*
>
> *Even knowing that you have to use it, I don't like it. (P10, male, 21 years)*

The approach on the use of condoms as part of health care is still often treated as a prescriptive procedure. However, this is considered complex as it involves both values and opinions

in terms of the emotional and sexual aspects[10]; therefore, it is important that the guidelines provided in services exceed the superficiality[11]. Moreover, although they do not absolutely ensure safe sexual intercourse[12], the condom use technique field is critical to the promotion of effective practice, and it is interesting that health professionals take advantage of educational technologies to achieve positive results for the development of skills in terms of the management of this method by the user[10].

The barriers related to (bad) taste or (bad) habit regarding condoms explained by the subjects seem to demonstrate that the longitudinal actions in monitoring the varieties of opinions do not constitute Health services reality[10]. A study involving 149 adolescents found that the discomfort and decreased pleasure in sex are among the main reasons for not using condoms[13].

Thus, the challenge is to aggregate educational activities to the discussion concerning health strategies that circumvent the difficulty of users regarding preventive practice[10] - such as the recommendation of the erotization of the condom, which has been an increasingly mentioned target in discussions in the midst of global conferences, in order to include in the healthcare services the incentive to promoting pleasure 5 and the dialog in terms of the benefits of individuals in relating sexually and feel at ease, when giving and receiving protection.

The HPM also seeks to understand the perception of individuals' self-efficacy related to the intended behavior, which comprises the judgment of their ability to perform such actions[8]. All participants perceived themselves able to getting in the habit of using condoms or to convincing the partner in relation to this behavior:

> *It's not something that we will not get used to. I get used to it. (P4, male, 42 years)*
>
> *I know I can convince him [the partner] to using it. (P7, female, 26 years)*

In the face of seropositivity, especially when elapsed little time of diagnosis, there may be a tendency for people to reflect in terms of prevention, with the feel of behavior change capacity. That interest must be stimulated by health professionals as a positive attitude[10] because, despite the fact that the sense of self-efficacy is not sufficient for processing and maintaining behaviors, we know the importance of this element as part of the health empowerment process[8].

The feeling related to the use of condoms in all relations was appointed by the subjects as a negative sense, because of the barriers commented; however it was a positive and peaceful feeling, for culminating with the conscious reaffirmation of practicing benefits, especially regarding the care for the partner in situations where he/she has no knowledge of HIV status of the other:

> *My wife is the one who relaxes me to change my attitude... it is the fact that I know that she does not have it [crying]. Can you imagine if I had infected her [with HIV]? I don't know. But if she gets infected... we will both treat it, right? (P4, male, 42 years)*
>
> *What I feel about changing? I only know it's boring to have sex with a condom, it's horrible. But I know I'm doing good for him [the partner]. (P13, male, 35 years)*

The advantage of discovering the feelings of individuals regarding their intention for behavioral change lies in the fact that, to know them, the most appropriate interventions for each person are identified while at the same time a positive feeling increases the likelihood of achieving what is expected, even in a long period of time[8].

In turn, interpersonal influences of the subjects regarding the use of condoms were investigated. This aspect implies that the behavior may or may not be influenced by others or social norms and models[8]. This applies to the opinions of sexual partners and by encouraging families regarding the use of condoms:

> *My family advises myself to take care of myself, for me to always use condoms in relationships. I feel weak because my husband does not cooperate. (P5, female, 40 years)*
>
> *He [the partner] asks to have sex without a condom and says, "I don't like it. So you find another partner or it's going to be like this. "(P13, male, 35 years)*

The reports indicated positive and negative interpersonal influences. The role of family members works as support and is relevant in the adaptive process of changes commonly performed when facing HIV. This situation can be exploited during health care in a special way, since the disclosure of diagnosis to the family is still a very common barrier.

The partner stood out as the main negative influential figure, and appears to be more fragile to change, especially for women. Similarly, homosexual couples can also be negatively impacted due to the non-perceived vulnerability to illness, accentuated by the impossibility of pregnancy[1] - a common thought among heterosexual couples.

Finally, situational influences consider that the environment can facilitate or prevent certain health behaviors[8]. In this logic, access to health services for the acquisition of prevention material was reported as an influence (positive) as well as the habit of using alcohol or other drugs (negative):

> *Whenever I'm running out [of condoms] I get them here or in the health center that is closest. (P5, female, 40 years)*
>
> *I still get kind of annoyed. I didn't use it every time, because the person was dramatic, these things; he got drunk and... (P2, male, 23 years)*
>
> *It's because he [partner] uses [male] condoms, but there are times when I don't know if I use it because before I used drugs as well. (P7, female, 26 years)*

It is true that to the free availability of condoms may facilitate its use among communities. However, the use of drugs causes greater exposure and vulnerability to various risks. An integrative review revealed that alcohol consumption is associated with a worse prognosis in patients with AIDS, because it may decrease adherence to treatment, as well as providing an increased occurrence of depression. Nevertheless, most health professionals do not investigate problems resulting from this behavior among service users[14].

Other problems related to the sexual health of the subjects after the diagnosis of HIV, in addition to the use of condoms, have been reported in the following category:

Category 2 - The suspension/restriction of sex life and lack of romantic relationships

When asked about behaviors that can have influence on sexuality and sexual health promotion, some study participants had the conscious intention and attitude of restricting or even suspending their sexual lives, although this was expressed as a desired behavior to be modified:

> *I do not have sex, but it's not because I don't like it. (P1, male, 41 years)*
>
> *I was in a relationship, and I ended it because of it [the diagnosis], [...] I invented an excuse. (P9, female, 50 years)*

A similar result was found in a study that sought to know aspects of sexual and emotional life of people with HIV, who demonstrated hindered sexual performance[9]. However, it should be considered that, in the universe of attitudes, people tend to incorporate the influence of specific historical period[1], which represents in this case the impact of recent diagnosis. Thus, the context in which life goes on may be able to drive people to the manipulation of facilitating/hindering signs in terms of behaviors that improve (or not) health[8].

It is worth emphasizing that, in this study, this aspect predominates in single subjects. However, they expressed a possible desire in terms of the (re)construction of sexual life and romantic relationships. The perceived benefits to this change were represented by welfare perspective and the desire of reproductive rights as a life project:

> *Isn't it horrible, you know, not to have anyone?! I would feel better; I would feel good about life. (P8, male, 46 years)*
>
> *Now I want to find a good person to get involved with because I still want to be a father, you know? (P12, male, 21 years)*
>
> *I can't be a father, right? Is it [HIV] transmitted to the kid? That's what I was obsessed about. My mother was asking. (P2, male, 23 years)*

Sexual life should be understood as a multifactorial aspect that integrates the network of meanings of social groups as it is marked by each culture[15]. The previous lines seem to refer to sexual life beyond the act itself and it may involve a series of feelings, such as the importance of having a companion, feel the other and understand reproduction as a possibility of a fruit resulting from a relationship.

Given the lack of information and the social stigma in terms of the infection caused by HIV, many women stated in a study carried out in Bahia that they have abdicated their desire to be a mother for the fear of transmitting the disease to their children[16]. This concern was also found in the speech of men in this study.

The approach concerning the sexual health needs in the services aimed at assisting HIV patients should be based on their right to decide freely and responsibly for reproduction, as well as access to information and materials necessary for the healthy exercise of sexuality without suffering discrimination. Currently, effective measures to avoid the risk of vertical transmission are adopted as protocol which starts from the family planning[17].

However, even with the advances that contribute to the stimulation of life projects in the field of sexuality and reproduction, the perceived barriers for the (re)construction of sexual life and relationships of the subjects of this study seem to prevail over the reported benefits. This applies to the sense of fear of transmission or falling ill by the perception of vulnerability, as well as the fear of prejudice or abandonment, especially if the partnership has significant emotional support. It is also possible to notice a sense that serodiscordant partners would live imprisoned to their condition, should they build a close relationship:

> *I met a girl at the disco. She keeps asking to see me... if I go, I can cling, and I don't want that for me anymore... not much because of me because I already have it [HIV]. This is for her to lead free life. And I could not say that I have the virus. [...] I think she'll get away. (P12, male, 21 years)*
>
> *I just don't date because I think I'm going to infect another human being. [...] This affects me you know? But what can I do? (P2, male, 23 years).*
>
> *It's hard to relate because, imagine if the person doesn't have it [HIV], and I say that I have and I infect her... it's over. (P13, male, 35 years)*

People living with HIV present, as a social survival, strategies for concealing the disease, because that way they can continue life as "normal" people, without being abandoned and discriminated against. This way of coping is present in all spheres of life, whether in the family, social life or at work. Similarly to that shown in the reports, in another study, the feeling of fear, justified on the basis of the consequences of the possibility of disclosing the diagnosis and fear in terms of the transmission of HIV, was also present[3].

So that barriers are addressed, it is crucial that people living with HIV or not, resignify the meanings related to infection. This includes reflection and increasingly open dialogue on issues related to sexuality and the establishment of serodiscordant or seroconcordant affective relationships, which should be governed by safe actions with regard to sexual intercourse without, however, overriding any deprivation of experience involving love, pleasure, companionship and intimacy[18].

Despite the desire for change expressed in practice and in the recognized benefits, the subjects did not seem to fully realize a self-efficacy regarding a possible confrontation problem that highlights an aspect of doubt:

> *There are times when I think I can take a new path and start in that direction. Sometimes I can't. I wanted to make a plan, to avoid keeping this idea in mind. (P13, male, 35 years)*

This sense in terms of a certain inability to change, even when a contrary desire is present, seems to demonstrate the need for help on the part of individuals, especially when it comes to those who have experienced existential conflicts arising from discrimination and compromised self-esteem.

Reflecting the fact that the construction of affective and sexual relationships is part of the social context, participants referred to the feeling related to this behavior with a sense of continuity of social life:

> *Dating again? Having someone with me? Oh, this idea makes me feel as if my life hasn't changed yet. (P9, female, 50 years)*

The presented sentiment highlights that commitment to social life is still a concern among people with HIV, and can also trigger stressful situations[9]. Thus, the creation of personal relationships is seen as a possibility of restructuring this aspect of life. However, individuals have expressed the reality in terms of the lack of interpersonal and situational influences related to the (re)construction of affective life:

> *I cannot have the help of my friends and family about it, because no one knows. I don't speak [about HIV] because no one understands. (P8, male, 46 years)*

The sexuality issues are very close and therefore hardly shared. Moreover, as the revelation of seropositivity is still a stalemate, the absence of individuals with whom they can talk about it reflects on the experience of a solitary process. In this field, the presence of health professionals is important for the psychological support and provision of other necessary supports[9].

Besides the difficulty in establishing affective bonds, other behaviors reported were expressed specifically by women, as can be noted in the next category.

Category 3 - Gender, power relations and the sexual health of women living with HIV

Among the study participants, two women reported the submission with regard to the partner's role (or ex's), within the context of their marital relationship as a habitual attitude that influences their health. This fact culminates in a feeling of weakness and sadness, even when the desire to change this condition is present:

> *I didn't feel good in the relationship with my ex-husband, because women are foolish when it comes to men. [...] I was invisible to him. (P3, female, 33 years)*

> *Good, but he [husband] doesn't like to talk to me, to get into an agreement, to use certain things [male condoms]. He may be experiencing this problem [HIV], but he doesn't want to take care of himself, so I told him "I look after myself and that's what matters to me." I need to take care of myself. Still, it makes me sad. (P5, female, 40 years)*

Power relations between genders, unfavorable to women, can turn into inequalities that undermine them, especially in the exercise of sexuality. In the context of AIDS, this problem makes the relevance of the feminization of the epidemic more apparent. The lack of autonomy, determined by the condition of submission in relation to the partner, disfavors women in finding effective mechanisms for the promotion of sexual health, prolonging their exposure to the risk of illness and causing low self-esteem and depression[19]. Thus, women's personal care constitutes a benefit as perceived by them in relation to empowerment.

The difficulties arising from socioeconomic disadvantaged among these women, which may be a reflection of infection pauperization process, affect its dependence/submission to the partner - fact represented as a perceived barrier before the desire to change attitude and consequent judgement of inability to perform it (self-efficacy). The situation seems even more difficult by the absence of positive interpersonal influences and fear of disclosing the diagnosis of seropositivity to family members (situational influence):

> *If I have courage, where do I go when he [partner] does not want me anymore? And my little son? To my family home it's not possible; they don't know about my disease [HIV]; they will ask about the medicine I take. (P3, female, 33 years)*

Conquering the well-being is linked not only to behavior but also to attitudes towards health - a concept that refers to the judgments, beliefs and values that may lead to certain behavior[8].

Based on this assumption, the female submission becomes a matter of attitude and therefore involves very complex issues in terms of a possible change, often grounded in the silence for fear of expressing themselves. The vision of empowerment as a necessity indispensable to overcome the problem of submission can be an element that favors the breaking of these silences. It is urgent the need to mobilize professionals and health managers in order to help these women to listen to their own voice and empower them regarding the appropriation of resistance strategies so they can value themselves.

Despite the negative behavior outlined by the participants, others mentioned the existence of positive attitudes related to sexual health, as discussed below.

Category 4 - Strengthening sexual life and relational affection

Despite the anguish in the lives of people living with HIV, some study participants kept their affective-sexual life active, reporting even the strengthening of their relationship, despite the short time after the seropositivity and recognition of sexual contact as a form of contagion. This expression was found to be prevalent among married subjects, both in seroconcordant as in serodiscordant relationships:

> *We are [participant and wife] carrying on... you have to move on! She's already giving me strength; we are even more united. (P4, male, 42 years)*
>
> *He [partner] is my companion, great person ... he got sick, and then, when I underwent mine [my test] it was positive as well. But, thank God, we had no problem with that. Our relationship is the same. (P9, female, 50 years)*

The possibility of maintaining affective-sexual relationships is considered a key issue for the well-being of people with HIV, as it contributes to a better quality of life. Sharing the diagnosis with the partner was considered important for coping with the disease, for the possibility of expressing your feelings, in addition to the discovery of new sexual experiences for the existence of emotional support[20]. As to the perceived benefits in relation to the continuity of the relationship, the partner was considered a source of emotional support by the subjects, manifested not only in relation to the sexual act, but for help in health care - such as the food and performance of daily activities, accompaniment to medical appointments and encouragement to accept treatment, reality also found in another study[20].

> *I'm pretty weak. [...] There are days when my wife makes me some porridge. When beans are ready she fixes me some. (P4, male, 42 years)*
>
> *I help him with care. Now he's so chubby... He lost 20 kilos; he was very feverish, he almost died. I came with him to this place [to work]. (P9, female, 50 years)*

In the situation of serodiscordant couples, this realization becomes even more pronounced due to the non-transmission of the virus to their partner. This should be worked during counseling to couples in services, since a negative diagnosis for HIV, even in situations where there was sexual exposure, can make an impression of non-vulnerability, especially when the person living with HIV has good adhesion to treatment or has an undetectable viral load, among other protective factors[2,20].

Nevertheless, the perceived benefits for maintaining affective bonding seems to stand out when compared to the perceived barriers, since the self-efficacy perceived by subjects demonstrates that they judge themselves able to do so. This perspective can be attributed to a greater sense related to the action, translated by well-being, probably derived from the revelation of seropositivity, and associated with influences. The latter refers to the support of children, as well as the partner's illness experience, making him understand that maintaining the bond between the couple strengthens the care of each other, eliminating the possibility of death.

> *It's for our good. What my wife's trying to do, she will do it while she can: give me support and strength. (P4, male, 42 years)*
>
> *We have to keep taking care of ourselves. Then my children say: "Mother, the person who has HIV is simply normal. No one can tell that you are sick. Only those who really know it, right mother?!" (P9, female, 50 years)*

The aspects represented in the speeches of the subjects should be encouraged by professionals, making it important to involve the family in this process, since it is more likely that people commit themselves to adopting health-promoting behavior when individuals considered important for them expect it and offer help[8].

ACTION PLAN FOR THE PROMOTION OF SEXUAL HEALTH: AN ONGOING PROCESS

After having expressed their behavior and desire for changing or maintaining such behaviors, participants were contacted for another meeting in order to share their impressions in terms of their sexual health. From this, an individual action plan, including what they considered important to their health at the time, should be developed. At the same time, it was necessary for the researcher to disclose certain important guidelines for the empowerment of the participants who were not even mentioned in the first meeting (perhaps because they are not so disseminated/stimulated in the social environment).

What happens today is that new risk reduction methods for HIV are being introduced, but people do not seem to follow their application in real situations. This applies to the existence - still incomplete - of the pre and post-exposure prophylaxis protocol (PrEP and PEP), or even the lack of family planning visits to couples and support groups to confront the female submission.

The combination of other strategies can also be used, such as male circumcision and the use of microbicides gel[2,12,20].

In general, the action plans drawn up for the problems identified in Category 1 involved the following nursing interventions: to show how to use female condom; work ways to overcome barriers for the use of condoms (erotization method, harm reduction in relation to the ingestion of alcohol or other drugs) in groups; advise on the need for adherence to achieve undetectable viral load; explain the importance of inviting the partner to carry out HIV testing and participate in counseling with health professionals; report on the availability of PrEP or PEP into service as user rights; present the existence of sexual practices with less risk, such as masturbation together; explain the difference in risk related to the type of sexual contact.

As to the problems in category 2, the following measures were agreed: assist in attempting to resume social routine and focus on pleasant thoughts; discuss concerns and stimulate the sharing of it with trusted people and; work reproductive rights and affective relationships in therapeutic groups.

Nursing interventions related to category 3 include: accompany women in the first meeting of the municipality's support groups (youth group and PositHIVas Citizens Movement); keep open dialogue in terms of their perceptions; forward them to the protection centers for women and; discuss women's empowerment and women's rights.

For the last category, individual action plans included, along with some previous interventions, the need for nursing consultation for couples and therapeutic groups in order to work the theme sexuality.

Faced with so many intervention technologies that should be considered important to the effectiveness of health promotion actions directed to people with HIV and their partners, it is essential that the interaction of individuals in managing their own care is strengthened and optimized all the time - mainly because it does not only involve the physical, but also the relational field, with its intimate matters of love and affection, so difficult to be understood and exploited. In this context, the light technologies - such as hosting, empathy, sensitive listening, therapeutic communication and assertive communication - take a privileged space and should not be forgotten by the professionals involved as mediators in this process.

CONCLUSIONS AND IMPLICATIONS IN TERMS OF PRACTICE

For a better understanding regarding the behavior analysis related to the sexual health of people living with HIV, using the HPM[8] proved to be a viable guide that allowed us to explore the biopsychosocial complex of the subjects in a manner that is dynamic and consistent with the nursing process logic.

Given the results, we could analyze that the previous behaviors related to the sexual health of participants seem to be based on beliefs of common sense and/or culture, in which we agree with the opinion regarding the absence of satisfactory pleasure with condom use, its non-practicality, the understanding that HIV is only prevented by using this method (and therefore the decision of not relating socially and emotionally with others), the thought - present even today - that being a woman involves submitting to man's desires, and the lack of guidance in terms of other forms of conducting sexuality in a pleasant and happy way.

In these aspects, knowledge in terms of seropositivity seems to show how a situation where behavior comes to be rethought so that the health of individuals and their partners is not jeopardized. At the same time, the behavioral change of desires and attitude as well as the perception of its benefits, appear permeated with fear of the stigma arising from the revelation of a socially condemned disease and the common lack of family support (and even marital) to decision-making. These care needs require individual and group interventions and action planning based on the needs and wishes expressed by the subjects.

The perspective of this work is also related to the sense of emphasizing the use of a nursing theory for its implementation, which represents an effort in the fight for the autonomy of the profession from the spread of its own knowledge geared for assistance.

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