



SOCIAL REPRESENTATIONS OF WOMEN SEROPOSITIVE FOR HIV ABOUT SEXUALITY

REPRESENTAÇÕES SOCIAIS DE MULHERES SOROPOSITIVAS PARA O HIV ACERCA DA SEXUALIDADE

REPRESENTACIONES SOCIALES DE MUJERES SEROPOSITIVAS PARA VIH ACERCA DE LA SEXUALIDAD

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ABSTRACT

Objectives: to understand how HIV women practice and interpret sexuality; to analyze the social representations of women seropositive for HIV. **Method:** qualitative, descriptive and exploratory study, based on the Social Representations Theory, developed with twelve women with HIV, *Positive Citizens Group* participants, enrolled in the referral service in Maceió-Alagoas, as approval of the Ethics Committee in Research of UFAL with Protocol number 14535413.8.0000.5013. A semi-structured form was used, and the data were subjected to content analysis technique. **Results:** of the recurring themes emerged: how and with whom did you get HIV/AIDS?; Sexual life after HIV/AIDS diagnosis; Condom use; The difficulty of negotiating for condom use; and Insecurity to talk about the serological condition with her partner. **Conclusion:** the difficulties for the exercise of sexuality are related to the transmission, generating negative impact on sexuality, feelings of guilt, anger and fear to tell to her partner. **Descriptors:** Women; HIV; Sexuality.

RESUMO

Objetivos: compreender de que maneira mulheres soropositivas exercem e interpretam a sexualidade; analisar as representações sociais de mulheres soropositivas para o HIV. **Método:** estudo qualitativo, descritivo/exploratório, fundamentado na Teoria das Representações Sociais, desenvolvido com doze mulheres soropositivas para o HIV, participantes do grupo *Cidadãs Positivas*, cadastradas no serviço de referência em Maceió-Alagoas, conforme aprovação do Comitê de Ética em pesquisa da UFAL com protocolo nº 14535413.8.0000.5013. Foi utilizado formulário semiestruturado e os dados foram submetidos à técnica de análise de conteúdo. **Resultados:** dos temas recorrentes, emergiram: como e com quem contraiu o HIV/AIDS?; A vida sexual pós-diagnóstico HIV/AIDS; O uso do preservativo; A dificuldade de negociação para o uso do preservativo; e Insegurança para falar da condição sorológica com o parceiro. **Conclusão:** as dificuldades referidas para o exercício da sexualidade estão relacionadas à transmissão, gerando impacto negativo na sexualidade, sentimentos de culpa, raiva e medo de revelar-se ao parceiro. **Descritores:** Mulheres; HIV; Sexualidade.

RESUMEN

Objetivos: comprender de qué manera mujeres seropositivas ejercen e interpretan la sexualidad; analizar las representaciones sociales de mujeres seropositivas para VIH. **Método:** estudio cualitativo, descriptivo/exploratorio, fundamentado en la Teoría de las Representaciones Sociales, desarrollada con doce mujeres seropositivas para VIH, participantes del grupo *Ciudadanas Positivas*, inscriptas en el servicio de referencia en Maceió-Alagoas, conforme aprobación del Comité de Ética en Investigación de la UFAL con protocolo nº 14535413.8.0000.5013. Fue utilizado un formulario semi-estructurado, y los datos fueron sometidos a la técnica de análisis de contenido. **Resultados:** de los temas recurrentes, surgieron: ¿cómo y con quién contrajo el VIH/SIDA?; La vida sexual post-diagnóstico VIH/SIDA; El uso del preservativo; La dificultad de negociación para el uso del preservativo; e Inseguridad para hablar de su condición serológica con el compañero. **Conclusión:** las dificultades referidas para el ejercicio de la sexualidad están relacionadas a la trasmisión, generando impacto negativo en la sexualidad, sentimientos de culpa, rabia y miedo de hablarlo con el compañero. **Descriptores:** Mulheres; HIV; Sexualidade.

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INTRODUCTION

This study is about the social representations of women seropositive for HIV about sexuality. The interest in this topic began in a graduation subject, on a debate about the increasing number of women infected, AIDS being a sexually transmitted disease. The way that these women practice their sexuality was a necessity of investigation established by the authors, therefore being the objective of this study. Another determining factor for choosing this objective was the scarcity of scientific literature about this topic in the state of Alagoas.

The social representations are several opinions, explanations and statements produced in a structured way, from the daily life of the groups, having communication as an important role in this process.¹ The social representation is a way of social common sense knowledge, which forms a general and functional knowledge to people, so the mental activity of groups and individuals can be related to situations, events, objects and communications of their concern.²

Since its beginning, the scenario of the epidemic of HIV/AIDS has been modifying in Brazil and in the world, which is reflected in changes in the epidemiological profile of people living with HIV/AIDS.³ This syndrome is a clinical manifestation of advanced human immunodeficiency virus infection (HIV-1 and HIV-2), which is a retrovirus consisting of RNA, from the family of *Retroviridae*, lentiviruses subfamily. HIV infection leads to immune dysregulation due to a progressive suppression, especially of cellular immunity.⁴ HIV is transmitted through unprotected sexual contact, percutaneous injection of tainted blood or, in the perinatal period, from mother to the child.⁵

Although the first clinical cases of AIDS have been detected in May 1981, in Los Angeles and San Francisco, USA, in male patients and homosexuals with exotic frames of pneumonia P. carinii Pneumonitis and Kaposi's sarcoma. A retrospective analysis, clinical epidemiological, is able to recognize the presence of the disease in Equatorial Africa, from 1960, in Simians, and later, in 1965, in native Africans. It is assumed, therefore, that HIV comes from Africa.⁶ In Brazil, the first cases of AIDS were confirmed in 1982, in the State of São Paulo. Of the total AIDS cases, more than 80% are concentrated in the South and Southeast regions. The Southeast is the worst hit region since the beginning of the epidemic and, despite the

high incidence rate, it shows moderate stabilization since 1998.⁶

The discussion about vulnerability in HIV/AIDS universe in men and women is recent, because until then the topic was treated as a health problem of groups considered at risk. Current studies have identified that the dynamics of the HIV/AIDS virus dissemination has been uneven among the vulnerable groups of the population and it is directly related to the behavior and the risk environment.⁷

Sexuality is an intrinsically element of social relations, the commitment of this sphere is limited, among other things, the condition of the person overcome the stigma representation contained in HIV infection, as well as their desired social normality. That normality characterized by the possession of all attributes which allow a full coexistence with others; among them, to be accepted by society.⁸

From these considerations, sexuality is understood as a peculiar way that each individual develops and establishes to live his subjective and collective relations. Then, the epidemiological impact of HIV/AIDS updated the device of sexuality in general and in particular of women, by aggregating issues to intimacy and sexual and reproductive health, in addition to presenting the imperative of new relational and gender practices.⁹

It is important to understand that for women, the social representation of AIDS, their knowledge daily prepared is configured differently than for men. It is necessary, then, to study the social representation of women on AIDS, to add data to literature about female sexuality and heterosexual transmission of the virus.¹⁰

Considering that sexuality is an important dimension in human life, where the sex is linked not only to reproduction but also to the affection of each one, it is essential to understand this aspect of the sexuality of people with HIV/AIDS, to promote adequate and humanized healthcare, breaking the paradigm of the biomedical model of health care that focuses on mainly biological aspects to caregiving.¹¹

In this context, the nurse as part of the multidisciplinary team, must assume his role as caregiver and educator, seeking to care people with HIV holistically and not limited to illness.¹² Thus, the objectives of this study are:

- To understand how HIV women practice and interpret sexuality;

- To analyze the social representations of women seropositive for HIV.

METHODOLOGY

Descriptive-exploratory study with a qualitative approach. The subjects of study were 12 women “Positive Citizens” (a group of women who are part of the RNP - national network of people living with HIV), registered at the SAE (Specialized Service Assistance) of the block I - Medical Assistance Center of Salgadinho (PAM Salgadinho). The contact with the collaborators of the study occurred by the fortnightly meetings of the focus group and in one of the monthly meetings of the National Network of People Living with HIV/AIDS-RNP.

The inclusion criteria were to be seropositive for HIV; 18 years old or more; to participate assiduously fortnightly in the “Positive Citizens” group, to be supported by SAE professionals; to be registered in the SAE of the block i - PAM Salgadinho, as a user of the service and attending the consultations; to be in physical and emotional conditions to answer the questions of the interview and voluntarily participate in the study. The exclusion criteria were women not assiduous in the group and consultations to SAE and women that by ethical or clinical reasons they could not participate in the study.

The scenario chosen for the accomplishment of this study was the block I of the PAM, located in Rua Mizaél Domingues, Maceió/ Alagoas, institution where the study subjects are assisted by service professionals and in the Espaço do Ser, situated on Rua Dr. Albino Magalhães, Maceió/Alagoas, space given for meetings of the “Positive Citizens” group.

The project was submitted to the Committee of Ethics in Research - CEP at the Federal University of Alagoas - UFAL, approved by Protocol number 14535413.8.0000.5013, and CAAE number 14535413.8.0000.5013. Before the interview, the participants were clarified about the objectives and research methodology explaining that their participation should be spontaneous and their identities will be preserved without possible risks of future embarrassment. After this, we applied the free and informed consent term (TCLE).

The instrument used for the collection of information was a semi-structured interview form, in order to obtain information about the profile and the difficulties of HIV women seropositive for HIV for their sexuality practice. The form covered general data, socioeconomic conditions, questions about HIV

serological condition and sexual behavior. The collection of information was in September 2013; respecting the saturation of information as advocates the qualitative research methodology.

The contents of the interviews were transcribed in full and analyzed based on Content Analysis. This method is defined as a set of techniques pursuing communication analysis, by systematic procedures and objectives description of messages, indicators allowing the inference of knowledge of the production and reception conditions of these messages¹³. Thus, it allows analyzing people's opinions in the stars, not restricting only the words expressed directly, but also to those that are implied in the speech of the participant.

The analysis created the following categories: How and with whom did you contract the HIV/AIDS? ; Sexual life after HIV/AIDS diagnosis; Condom use; The difficulty of negotiating for condom use; and Insecurity to talk about the serological condition with her partner.

As a way of uncovering the topics about the difficulties experienced by HIV-positive women about sexuality, we chose to work with the Social Representations Theory, classifying the findings within the questions.

The Social Representations Theory (SRT) is about the manner in which individuals seek to understand the world around them, considering not only manipulating information or acting without explanation. Above all, they think. In this way, the SRT is a way of knowledge of common sense which coexists with scientific knowledge. Thus, the social representations is the way the individual thinks and interprets his daily lives, constituting a set of pictures with a reference system that allows interpreting his life and sharing that interpretation with his social environment.¹⁴

RESULTS

This research was held with 12 seropositive for HIV women from 38 to 61 years old that met the inclusion criteria. To identify them, names of precious stones were used for the preservation of the identities of the participants. They range of age, education, marital status, place of birth, address, income, among others.

In relation to education, one of the interviewees is not literate, six have the 1st grade incomplete, of them, one is attending it, one has the 1st full grade, three have completed high school and only one has completed higher education.

Of the respondents, not all were in the labor market. Five are housewives, for some of them this fact is related to the compromised state of health, and others referred to the difficulties that people living with HIV/AIDS face to join and remain in the labor market, after the diagnosis. The other had various professions: house cleaner, diarist, teacher, designer, marketer, artisan and health agent. Income ranged from less than one to four minimum wages, but most of them have a minimum wage.

With regard to marital status, six interviewed are single, three are widows, two

are divorced, and one is in consensual union. We emphasize that at the time of conducting the interview five women had no affective relationship. Regarding the current partners, five are positive for the serology of HIV/AIDS, and two have unknown serology. It is important to mention that only two women do not have children, and the other had them before of HIV infection.

The lines by the participants of the study led to the development of Figure 1. In this figure there are the categories and part of the main clippings related to the sexuality of women with HIV.

Categories	Statements
How and with whom did you contract the HIV/AIDS?	<i>I don't know. It was all of a sudden, right? How do I know? (Rubi); No, that is a question that is a little complicated, because the person who transmit it to me didn't told and I believe he didn't know too. (Jade); No, I don't know and want to know, but I have no way of knowing. (Pérola); Well, I get it with my husband, he is a truck driver. (Ametista); In a relationship. I was dating him for a long time. (Cristal); I know right? In intercourse with my husband. (Turmalina); It was with my ex-husband, in sexual intercourse. (Ônix)</i>
Sexual life after HIV/AIDS diagnosis.	<i>I want to use a condom to not transmit HIV to someone, but he thinks because you're clean, you're smelling, you see nothing, no wound in you, then he has to have sex without a condom? No. So, consciousness is mine, to make him use it or not. When you get to that point, I prefer to leave, and keep him away from me, not looking for him anymore. It's awful, it's scary. (Jade); Sex for me, let me see, I told you but I do sex with women, and it has changed for the better for me, much better. I have no barrier (referring to emotional/psychological barrier) No, nothing, we understand very well and that's it. (Ônix); Look, what has changed is just the condom, which I use today, before I didn't use it too much before, today I do. Don't we take a shower? Don't we eat? Then, the condom today for me is something like that, it's part of my life. (Topázio)</i>
Condom use	<i>With my partner only in the first three months of dating, and after that we started to live together, he said "why do you want it?" (Quartzo); [...] It's like I told you, you're in a relationship, you start with the condom and after a while you end up abandoning and here's the big problem. (Cristal); I always use it, then when I went to live with him he began to want to not use it, but to me it was always with a condom. (Safira)</i>
The difficulty of negotiating for condom use	<i>If I have sex today and say: "I want a condom", usually they ask: "Why using a condom? Are you sick?" it's happened several times to me (...) and for me, I lose the appetite, you understand? (Ametista); The biggest barrier is the partner using a condom. Then they say "what for? You have nothing, I have nothing."(Quartzo); [...] What I think is bad is because they keep asking why do you have to use the condom, and when they didn't want to, what can we do, right? (Diamante); [...] you even try, I've even tried, but then the person says "why? You are such a beautiful woman, so healthy and everything, you got nothing, why do you want to prevent?" And it blocks, there's no way you have more, it's over, the sexual appetite goes away in time. (Pérola)</i>
Insecurity to talk about the serological condition with her partner.	<i>And when I say I am, that's even worse, because he will run away from me, so for this reason, I don't want anymore. (Ametista); ... for me it's complicated at this point, to tell him today that I have a disease, because then I get scared to tell him I have HIV because I contracted with someone else. (Jade); What changed everything in my life was a sexual relationship, a new partner that I can't face it, because I won't have the guts to tell him [...]. (Pérola)</i>

Figure 1 - Presentation of the categories and statements of the twelve women seropositive to HIV participants of this study.

DISCUSSION

- **How and with whom did you contract the HIV/AIDS?**

In the group of the interviewed, seven women were infected by her husband and/or stable partner, four women cannot identify who has infected them and there was one suspicion of infection through injecting drugs use sharing syringes in groups. One of the

explanations for the feminization of the epidemic would involve belief in monogamy, women feeling protected in stable relationships from contamination by HIV/AIDS.^{14,15}

The no identification of how and with whom the disease was contracted, as revealed by four of the women interviewed, seems an indicative of the existence of more than one sexual partner, being still revealing that

sexual intercourse took place without adequate protection.

No, that is a question that is a little complicated, because the person who transmit it to me told me that I believe he didn't know. (Jade)

No, I don't know and want to know, but I have no way of knowing. (Pérola)

More than half of public service users of São Paulo does not use protection in sexual intercourse, whether or not fixed partner, exposing themselves to reinfection and infection of others.⁹ The woman would rely on her monogamy, giving that sentiment to her partner, depending on the intimacy and conviviality.¹⁴ That is, monogamy may lead to abandonment of ways of protection, when used, as suggested by interviewees who have contracted the virus with their partners. They seem to demonstrate that sexual intercourse without a condom is a result of confidence in the partner's fidelity, not having the self-perception of vulnerability to STD/HIV/AIDS.

Because we start dating, flirting, then you begin to have sexual intercourse with a condom, but at a certain time dating ends up, you start to forget and you trust that person, that person trusts you. (Cristal)

In some cases, the use of a condom is not used due to belief in partner's fidelity, also for fear of appearing as infidel or express a lack of confidence in the relationship.⁹ Thus, it is noted that the interviewed extend the trust they have in their own behavior to the partner, without considering the possibility to be before something really impossible to ensure. To speak for her, in her sure fidelity, this speech can only be sure in herself and not to any other person.

♦ Sexual life after HIV/AIDS diagnosis.

Among the interviewed, six women reported that they did not have sexual intercourse changes, only condom use was added, and they reported to be adapted. Three of them opted for abstinence because they deal with fear and insecurity during the sexual act. Two of them say that sexual intercourse has changed for the worse, and one just says that it changed for the better, and assigns to this fact the change of sexual orientation, currently being homosexual.

One of the main difficulties cited by the interviewees are the following: relationship with a partner negative for HIV; fear of infecting someone; mandatory condom use. The negative or positive HIV between the partners as well as in other contexts, in which HIV is present, still presents difficulties in acceptance by the population. As a rule, it leads to judgments, reactions of indignation

and condemnation, social reason for the partner's tendency to escape and the secret.¹⁶

Among the women interviewed, informing that there were negative changes and even abstinence in their sexual activities, we observed that this is from the way they deal with the disease about their sexuality and towards others. It is important to note that all of them know the way of transmission of the HIV virus, but still demonstrate insecurity and fear of transmitting the virus in their lines:

I was flirting, very well, dating a lot, kissing, hugging, but when it was the time go on a serious date, then oh back off, I said, okay, other day, not now - so, I was running away from him very fast, because of fear, I panicked to have relationships, understand? Okay, so, I chose to not going through this shame, this emotional wear for me, because ... I preferred to go away. (Ametista)

[...] I want to use a condom to avoid passing HIV to someone, but he thinks because you're clean, you're smelling, you see nothing, no wound in you, then he has to have sex without a condom? No. So consciousness is mine, to make him use it or not. When you get to that point, I prefer to leave, and keep him away from me, not looking for him anymore. It's awful, scary. (Jade)

When discovering the pathology, people with chronic diseases, such as HIV can interfere particularly with sexual desire, because they are more concerned with the symptoms that may appear (fever, diarrhea, and opportunistic infections) and the decrease of desire, sexual activities or sexual abstinence might be part of their behavior.¹⁸

The individual HIV-positive, temporarily or definitively discontinues the sexual activities after learning that is he infected, because of the difficulty of efficient adaptation and this comes from much more psychological factors (fear, guilt, insecurity) than physical.¹⁸

It is common to identify women who due to a diagnosis of HIV infection, have restricted or abolished their sexual practices, even if they have not lost their sex desire. Several feelings collaborate to this to happen. As an example there is the fear of disclosure of diagnosis; the fear of transmission of the virus and the feeling of the limitation imposed by the need of condom use.⁸

For me it's something very badly resolved now, as a woman seropositive. I don't know if I'll be able to have a new relationship, having a pleasurable sex life, healthy love with someone, you know? It's a very big conflict yet (...). (Cristal)

The sexual dysfunctions have been described with high prevalence among women in the general population and conflicts have

important impact on sexual function. In HIV women, high prevalence of sexual dysfunction was detected.¹⁹

In a study conducted with HIV women, it was described that the HIV carriers are faced with multiple psychosocial stressors at all stages of the infection. Certain stressors change the lifestyle and require adaptations. Some authors have pointed out that the fear of sexual transmission increased with AIDS, both in subjects infected as uninfected. It is common to find individuals who have suspended the sexual activities or people who have sex, and somehow have impaired sexual activity.¹⁹

To the other women interviewed, the discovery of the diagnosis itself does not hurt the experience of their sexuality as regards knowledge of your body, the desire, the quality/quantity of sexual intercourse and the pursuit of pleasure. The changes reported were condom use, since before they did not use it, and there was a woman who reported that it has changed for the better, due to the change in sexual orientation.

Sex for me... let me see, I told you but I do sex with a woman, and it changed for the better for me, much better. I have no barrier (referring to emotional/psychological barriers) No, nothing, we understand very well and that's it. (Ônix)

Look, what has changed is just the condom, which I use today, before I didn't use it too much before, today I do. Don't we take a shower? Don't we eat? Then, the condom today for me is something like that, it's part of my life. (Topázio)

The feelings in relation to sex, to sexuality and HIV are complex and often conflicting. The effects that can be expected of these conflicts are several, but in some studies it is shown the difficulty to the exercise of sexuality, with the positive diagnosis for HIV. For many people, the first answer, after receiving such a diagnosis, leads to decisions like abstinence and the perception of HIV infection as a loss of sexuality. Sexuality, facing the risk adopted by many researches and professionals and the social response given to HIV, is revealed and constructed, often in a stigmatized way.¹⁹

Sexuality, like any other area of social life, has close relationship with the socialization process and with learning the rules of the society, from the social process, operating within the fields of power, and not simply a set of biological stimulus they found or not a direct release. Sexuality beyond the genital and reproduction, and would be closely linked to the integral development of the subjects, in addition to representing a very important

part in structuring their personality, modelling social and sexual relations of individuals.²⁰

It is from these considerations that we understand sexuality as a peculiar way to each individual to develop and establish to live their subjective and collective relations. Then, the epidemiological impact of HIV/AIDS updated the device of sexuality in general and in particular of women, by aggregating questions to intimacy and sexual and reproductive health, in addition to presenting the imperative of new relational and gender practices.⁹

♦ Condom use

Of the 12 women respondents, three of them are in sexual abstinence, of the nine having active sex life, four use the condom in all sexual intercourse, two use it sometimes and three of them depending on her partner's choice. Those who use it sometimes or depending on her partner's choice recognize the importance of it, and one of the factors of non-use it is the partner also being HIV positive and show resistance to its use.

Of all the respondents, nine did not use a condom before diagnosis of HIV/AIDS, and three used it at the beginning of the relationship, leaving its use with the passage of time.

With my partner only in the first three months of dating, and after that we started to live together, he said "why do you want it?" (Quartzo)

I always use it, then when I went to live with him he began to want to not use it, but to me it was always with a condom. (Safira)

Prevention is still the main way of coping with the AIDS epidemic. One of the causes of disease increasing in the population is related to the use of condoms: men use more condom than women. In addition, they are more accustomed to bring the condom and have it available at the time of sexual intercourse than women. In sexual intercourse with casual partners in the past year, 51% of men and only 34.6% of women used condoms. Gender inequality facilitates the submission of women in relation to man and makes it difficult to negotiate condom use. It is a factor of female vulnerability that exposes to higher risk of HIV infection.⁹

The requirements that the AIDS epidemic brought to intimacy seem to conflict with some issues related to the constitution of the sexual relationships in the hegemonic feminine universe, marked by a way of experiencing the sexual fulfillment by the ideal loving encompassed. In it, the total dedication and the desire to merge with each other, symbolized in the sexual act, clash with

the normative prescriptions of condom use, representing a symbolic barrier, in which the “distrust” opposite to love pact, is placed.¹⁹

It is also important to review the use of condom and safe sex not by the threat and the risk, but the possibility to experience sexuality safely and free from coercion. The exercise of sexuality must be ensured irrespective of serological condition.¹⁹

Guidance on the use of the condom is something that still needs to be widely discussed in the health services. When dealing with this issue with individuals, it is necessary to enhance the feelings, doubts and perceptions about this usage, and above all that this thread is not marked by a normative tone, but they are discussed the possibilities of realization of sexuality and discussed the vulnerability of women with her partners, who must get along with them ways of resolution or better topic handling.²¹

♦ The difficulty of negotiating for condom use

For the women in the study, one of the biggest difficulties faced to the natural exercise of sexuality is the sexual partners' resistance to condom use. Such situation is worse when there is a single woman with an eventual partner, because they make questions making the woman with HIV remembering the disease, and all this caused disorders, leading her to thoughts that inhibit the moment satisfaction, generating blocks and afflictions resulting in frustration and desire to escape, as seen in the following lines:

If I have sex today and say: “I want a condom”, usually they ask: “Why using a condom? Are you sick?” it's happened several times to me (...) and for me, I lose the appetite, you understand? (Ametista)

[...] What I think is bad is because they keep asking why do you have to use the condom, and when they didn't want to, what can we do, right? (Diamante)

[...] you even try, I've even tried, but then the person says “why? You are such a beautiful woman, so healthy and everything, you got nothing, why do you want to prevent?” And it blocks, there's no way you have more, it's over, the sexual appetite goes away in time. (Pérola)

Some women do not have access to information on sexuality and reproductive health, limiting control over their own bodies and about the decision-making about their sexual in a secure manner, in spite of HIV. In general, they feel inhibited and powerless to negotiate condom use with the partner, fear of generating suspicion of infidelity; and refusing the sexual relationship if the partner refuses to use a condom is even harder.²²

The condom is not easily adopted on sexual relations between men and women. Historically, the use of condoms is associated with prostitution, promiscuity and extramarital relations. From this, it results embarrassment and distrust between partners for its acceptance. Also to that bad reputation of the condom, there is the perception that it bothers, hinders the erection and affect sexual pleasure.²²

This fact shows that, even though there were important changes in the systems of sexual meanings, especially among the middle and upper classes, in addition to the achievements that the feminist movement has achieved in recent decades, among the least favored sexuality is still subjected to traditional models, in which the weight and power of machismo still commanding sexual relations. In this way, a large number of women are subject to the desires of their partners, not practicing protective attitudes.²¹

In sexual relations between men and women, the difficulty in negotiating the condom use can be understood as an example of the crossings gender's assignments historically constructed. Because, in our culture, many times, the fact that a woman carrying a condom shows she is available sexually, causing their fear to propose its use at the time of the relationship, and, in addition, some of them may be afraid to suffer physical or psychological violence. Also, there are elements that the condom puts at risk the ideal of romantic love and the prospect that the woman he loves must surrender unconditionally to the partner.²³

In fact, there is a socially constructed behavior, which preaches the penetration as legitimate proof of sexual activity and see the condom as an obstacle. This makes women and men more fragile and vulnerable, by limiting the expression of sexuality.²²

Safe sexual practices involve complex mechanisms. Social representations permeate the exercise of different sexualities, which are present in interrelationships of gender. Study in Switzerland with heterosexual couples showed that in sexual contacts in which had equity of power, the use of the condom was more frequent. However, it decreased in older couples and couples in which the men had greater power within the relationship.²²

There no discussion on AIDS and its coping without understanding social relations of gender and its implications in the affective and sexual interactions between men and women. The adoption of preventive measures, such as condoms, coming up on issues on

which it is difficult to have a dialogue and requires the overcoming of social, cultural and emotional barriers. To overcome these obstacles is an arduous process, at the same time it is necessary so that the real threat to the lives of thousands of men, women and children around the world is overcome.³

◆ **Insecurity to talk about the serological condition with her partner.**

The insecurity, the fear of speaking of serological condition to the partner, fear to his reaction, the possible expulsion and exposure of the health situation as something intimate represented the women interviewed in this study. This feeling sometimes resulted in sexual abstinence, due to the difficulty of revealing the diagnosis.

And when I say I am, that's even worse, because he will run away from me, so for this reason, I don't want anymore. (Ametista)

What changed everything in my life was a sexual relationship, a new partner that I can't face it, because I won't have the guts to tell him [...]. (Pérola)

Faced with the possibility of living with HIV for an indefinite period, to reveal to others that the situation of the seropositive condition has become one of the central issues of the AIDS epidemic.²⁴ After the discovery of the positive diagnosis, the person experiences intense suffering anguish and fear, beyond sadness, faced with the possible and still uncertain life changes. Often the fear of expulsion of the partner and marital changes arising from HIV revelation.²⁵

The revelation is also differentiated on gender issues. The study notes that women are the ones that reveal fear contamination and the possibility of transmitting HIV to their partner, reaffirming the care aspect with the other as a feminine role.²⁶ But surely the aspect very present in the moment of revelation and perhaps the most complex and difficult to deal with is the stigma.²⁶

The discrimination that the stigma requires is an important limiting disclosure of diagnosis in the context of HIV, just assumed or experienced in practice.²⁵

CONCLUSION

This study allowed the analysis about the social representations of women seropositive for HIV about sexuality. It showed that as important as physical care, there is the emotional care, since it causes several feelings, generating internal conflicts.

The difficulties showed for the exercise of sexuality of women with HIV/AIDS are multifactorial, related to factors of several

natures. The first factor may be related to the way of transmission for HIV, being a syndrome acquired through sexual intercourse, causing negative impact on the exercise of sexuality, and consequently sexual inhibition, related to fear of transmitting the infection or to reinfect, feelings of guilt, anger, fear of revealing to the partner or physical violence and many others related to HIV.

The reduced libido for the most part is transitory, the health professional must be able to deal with this matter in order not to underestimate this aspect of HIV woman's life, offering support and open their minds to share this situation with naturalness, favoring the positive exercise of sexuality.

We observed in this study the relationship of power that the male gender exerts on the female sexual relations, because of the difficulty that all women reported to negotiate condom use in sexual intercourse. We identify the lines of women who maintain active sex life without the use of condoms, partner's refusal to accept the condom for a personal matter, and the fear of being questioned for the reason of the requirement. Given the above, it is clear the strong cultural influence that takes the woman undergo unsafe sexual practices for fear of being questioned in her fidelity or feel obliged to reveal their seropositive HIV and being exposed to prejudice and neglect.

As social representation we found fear and insecurity, being aspects of these women's lives who deserve to be treated openly and without prejudices, resulting in an effective and efficient care, focused on listening to their troubles and desires, with the purpose to minimize emotional distress inherent in serological condition and avoid unprotected sexual practice and unsatisfying. Therefore, it is important that the health care professional, regardless of their personal beliefs or preferences, be available to assist women to find enjoyable and safe alternatives in life with HIV/AIDS, so that sexuality is a source of satisfaction and pleasure.

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