ORIGINAL ARTICLE

FEELINGS AND EXPERIENCES OF WOMEN WITH SEXUALLY TRANSMITTED INFECTIONS

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Highlights:

(1) Guilt, sadness, and shame marked the STI diagnosis among the participants.

(2) Trust in partners was a risk factor for STIs among married women.

(3)](3)Social stigma and frustration over not breastfeeding impacted maternal experience.

PRE-PROOF
(as accepted)

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FEELINGS AND EXPERIENCES OF WOMEN WITH SEXUALLY TRANSMITTED INFECTIONS

ABSTRACT

Objective: to describe the feelings and experiences of women exposed to sexually transmitted infections. **Method:** qualitative study, conducted with seven women in a reference center for the care of women in a municipality on the western border of Rio Grande do Sul. Data were collected in December 2020, through semi-structured interviews and the Dynamics of Creativity and Sensitivity, submitted to content thematic analysis. **Results:** participants indicated prejudice and judgment among family members and friends. Regarding transmission, women did not use condoms during sexual intercourse because they had a fixed relationship. Stood out in the lines, the feeling of frustration for not being able to breastfeed their children. **Conclusion:** the need to disseminate information about sexually transmitted infections is identified, since most of the participants had incipient knowledge on the subject.

Keywords: Sexually Transmitted Infections; Sexual Behavior; Health Vulnerability; Women's Health; Nursing.

INTRODUCTION

Sexually transmitted infections (STIs) are caused by microorganisms such as viruses and bacteria, these diseases are mainly transmitted through sexual intercourse without barrier protection, whether oral, vaginal or anal[1]. The main consequences on health are related to the quality of life of people who are affected by diseases, which impacts their personal, social and family relationship[1].

At this juncture, the epidemiological and operational indicators of STIs worldwide have been worrying for health professionals in the various services, since Acquired Immunodeficiency Syndrome (AIDS) still represents a serious public health problem, with a load of more than 42.3 million deaths occurred by the year 2023[2]. In addition, annually five hundred million people are infected with one of the curable STIs and a large part of these develop damage to their health because of the infection[3].

In addition, when analyzing the indicators of the Unified Health System (UHS) in Brazil, it is noticed that the country also faces challenges regarding STIs. In 2022, the Americas recorded the highest absolute incidence of new cases of syphilis in the world, totaling 3.37 million. This figure corresponds to a rate of 6.5 cases per 1,000 people, accounting for 42% of all new infections globally this year[4].

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In view of the above-mentioned indicators, the Pan American Health Organization (PAHO) established the Action Plan for the Prevention and Control of HIV/STI, which proposes to eliminate by 2030 the epidemic of the HIV virus and STIs in Latin America. Currently, this phenomenon has been promoting significant threats to the treasury of the countries that make up this group[5]. However, for this plan to be transfigured into plausible and applicable, it must take into account the importance of working on the aspects that permeate the sexual health of the population, since this is a strategy for health promotion and development of human beings[5].

Regarding women's sexual health, their sexual and reproductive rights stand out, even though they are provided for in public and social policies, they are not effectively guaranteed6. Often, women face obstacles to cease with the cultural context of subordination, historically determined by men and marked by rules and taboos still present in society, which control and repress their bodily experiences in sexuality and reproduction[3].

Faced with these challenges, it is noted that unequal gender relations, biological and anatomical characteristics, and the level of education are factors that lead women to become even more vulnerable to exposure to STIs. Difficulties in accessing health services and misunderstanding of information on prevention and treatment measures are aspects that contribute to women having unprotected relationships and exposure to STIs[3].

Moreover, in the female imagination, there is a persistent belief that people in stable relationships are immune to STIs. Many women are unaware of their own vulnerability and believe that exposure to STIs is associated only with people with risky behaviors. In this sense, it is justified to conduct studies that allow the collection of theoretical data to direct health professionals, especially nursing, with scientific evidence for decision-making and planning of comprehensive care through prevention strategies and reduction of social stigma still present in the theme.

The STIs can lead to severe physical and emotional consequences, which can be translated into feelings and experiences that remain in people's life trajectory. Women exposed to STIs may experience fear, insecurity, sadness, shame and infidelity due to the reactions of their family and partner[8]. Nursing plays an important role in educational actions and prevention of STIs and health conditions, especially in the Primary Health Care (PHC) services[9].

Studies aimed at the feelings and experiences of women with STIs can contribute to the identification of emotional and social barriers that hinder early diagnosis, appropriate treatment

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and prevention of these diseases. Understanding these experiences can assist health professionals in developing more empathetic and effective approaches, contributing to the reduction of stigma associated with STIs and to the promotion of women's overall health. Given the above, the objective of this study was to describe the feelings and experiences of women exposed to sexually transmitted infections.

METHOD

This is a qualitative, field and descriptive study. To improve the quality and transparency of the information contained in the manuscript, the guidelines of the Consolidated Criteria for Reporting Qualitative Research (COREQ) were followed[10].

The study was conducted in a Reference Center for Women's Health, located in a municipality located on the western border of Rio Grande do Sul, Brazil. The choice of scenario was given because it is a specialized service and aimed at women, which would allow greater ease in access to participants.

The selection of participants occurred for convenience, involving women in follow-up in the health service who agreed to share their feelings and experiences. Thus, the inclusion criteria involved women aged 18 years or more and diagnosed with STIs at some point in their lives. There were no refusals or withdrawals of participants during data collection. However, seven interviews were excluded because the participants did not report having received a positive diagnosis for STIs throughout their lives.

The acquisition of new participants was terminated when the data saturation criterion was reached. In this sense, after each collection, the audio transcription was carried out and it was evaluated if the answers provided by the participants included aspects such as homogeneity and diversity. When it was realized that the information began to be repeated and that the objective of the research had been achieved, it was decided to end data collection[11].

Women were invited to participate in the study after medical consultation. The data collection occurred individually, in a private room in the service itself, provided by the nurse responsible for the service.

Data were collected in December 2020, during the Covid-19 pandemic. The researchers were previously trained on the use of Personal Protective Equipment (PPE), following all safety measures indicated by the coordination of the service in which the research was developed and the recommendations of the World Health Organization (WHO). The researchers were also

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previously trained to perform data collection by the responsible researcher, who has experience and expertise in studies with a qualitative approach.

For data collection, the semi-structured interview technique was used, using a script previously prepared by the researchers, with closed and open questions that included sociodemographic data on participants and questions related to the research theme. No pilot test was conducted.

To complement the interview, we used the Creativity and Sensitivity Dynamics (CSD) called "Almanac" and "Body Knowledge"[12-13]. The CSD "Almanac" involves the cutting of images and diversified words for the creation of an artistic production by the research participants, from a research question signaled by the researchers[14].

To execute the "Almanac" technique, craft sheets, images and words from magazines and printed materials were made available. This material was maintained during the production of data for all participants to access, in order to ensure uniformity in the process. The construction of the "Almanac" occurred independently and individually by each participant.

The data collection began with the CSD "Almanac", and the participant was asked to answer the guide question: "Tell me what you know about sexually transmitted infections". As participants chose the images and words to build their artistic production, some questions from the interview script were developed, such as: What do you think people could do to prevent/not have a sexually transmitted infection? What care do you consider important? Why do you think it is important to perform this care? In what situations or with which people should we take such care? Who taught you to have and do such care?

Subsequently, the CSD "Body Knowledge" was carried out, which consisted in providing to the participant a craft sheet with the design of the silhouette of a body, allowing it to scale the process of caring related to the physical body[12]. Thus, from the metaphor of drawing a body, the participant recalled the care practices, developed in different contexts, involving the ISTs. To start the production of CSD "Body Knowledge", was launched the guide question: "how do you take care not to be contaminated with a sexually transmitted infection?".

As participants were drawing, other questions from the interview script were carried out to deepen the conversation. Among the questions, one can cite: How do you think a person "gets"/becomes infected with a sexually transmitted infection? How can a person find out that they have a sexually transmitted infection? What symptoms can a person with a sexually transmitted infection have in the body? Do you think you can treat/cure a sexually transmitted

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infection? What do you know about treatments for sexually transmitted infections? Have you ever had a sexually transmitted infection? What was it? How did you find out and how did you treat yourself? Would you like to say something else that was not questioned in the interview? If you want, we can offer a blank page for you to write in case you feel ashamed to speak.

At the end of the construction of artistic productions, the researchers made a photograph of each "Almanac" and "Body Knowledge". The interviews were audio-recorded with the participants' authorization. The average duration of each data collection was 15 minutes.

Next, the material was transcribed by the researchers and submitted to the thematic content analysis of Minayo15. This technique is divided into three stages: 1) pre-analysis; 2) exploration of the material; 3) treatment of the results obtained and interpretation. In the first stage, organization and in-depth reading of all collected materials was carried out, seeking greater understanding of the data. For this, the transcriptions were reproduced in the Microsoft Word program and the artistic productions of the CSD were digitized and stored in a folder in Google Drive, with restricted access to researchers.

In the second step, from the tools available in the Microsoft Word program, significant terms and/or expressions were highlighted in order to define categories, identifying the units of significance. Also associated with artistic productions related to these terms and/or expressions.

In the last stage of the analysis, the results obtained from theoretical references in women's health were interpreted. It should be noted that the data were not returned to participants for comments or corrections.

The study fulfilled all ethical precepts. The research project was approved by the Research Ethics Committee on November 10, 2020, being registered under opinion number 4.390.633 and CAAE 39479720.0.0000.5323. The women signed the Informed Consent Form, before the beginning of data collection. In order to preserve the identity of the research participants, we used the letter "W", initial letter of the word woman, followed by a numeral.

RESULTS

Sociodemographic characterization of study participants

The participants in the study were between 21 and 42 years old. Three had incomplete elementary school, an incomplete high school and three with complete high school. Regarding the marital status, four were unmarried, one had a stable union, one was divorced and one was married. Four participants declared themselves black and three white. Three reported living

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with the HIV virus, two reported having already contracted syphilis, one gonorrhea and another showed having discovered the human papillomavirus (HPV) during pregnancy, as shown in Chart 1.

Chart 1 - Sociodemographic characterization of participants, Uruguaiana, Rio Grande do Sul, Brazil, 2024.

Code	Year of birth	Education	Marital status	Occupation/ Profession	Lives with	Children	STI
W1	1990	Incomplete elementary school	Married	Housekeeper	Family	Three	HIV
W2	1978	Incomplete high school	Divorced	Domestic worker	Children	Two	Syphilis
W3	1999	Incomplete elementary school	Single	Housekeeper	Children	Two	HPV
W4	1997	Complete high school	Stable union	Hairdresser	Alone	One	Gonorrhea
W5	1990	Complete high school	Single	Domestic worker	Children	Two	HIV
W6	1984	Complete high school	Single	Housekeeper	Family	No children	Syphilis
W7	1995	Incomplete elementary school	Single	Domestic worker	Alone	No children	HIV

Source: created by the author.

The results were organized into three thematic categories presented in Chart 2, these being: sociodemographic characterization of the study participants; Feelings of women exposed to sexually transmitted infections and Experiences of women exposed to sexually transmitted infections.

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Chart 2 - Organization of themes based on registration units, Uruguaiana, Rio Grande do Sul, Brazil, 2024.

Categories	Subcategories	Units of record
Women's Feelings About Sexually Transmitted Infections	Women's feelings and reflections on sexually transmitted infections	Sadness; helplessness; guilt; shame; loneliness; stigmatization
Women's Experiences About Sexually Transmitted Infections	Experiences after being diagnosed with a sexually transmitted infection	Breastfeeding prohibition; judgment from others

Source: created by the authors.

Women's feelings about sexually transmitted infections

The participants expressed feelings of guilt, sadness and anger for having acquired STI. Most of the participants reported that they were to blame for their lack of care during sexual intercourse. Such as the lines and the figure below selected by participant W6 to represent their feeling. Also, there was an episode of sexual abuse mentioned by participant W7, which exposed her to HIV.

> To this day, I feel sad because if I had known that condoms would prevent so much, I would have used them. (W1).
> I feel stupid because I could have avoided it, but I surrendered myself to love. Now I have to suffer the consequences. (W2).
> My mother was right. She said I was stupid for getting this disease [STI]. (W3).
> I didn't take care of myself [...] It's all my fault. I should have used a condom. (W4).
> I'm so angry at myself because I allowed myself to get this disease. After I found out, not even my mother wanted to hug me, and she's right. I feel like I ruined my life. (W6).
> I got infected through lack of strength and bad luck. If I had had the strength to get rid of it, I wouldn't have gotten HIV. (W7).

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Image 1 - Image selected by participant M6 to create her almanac. Source: Google Images (2020).

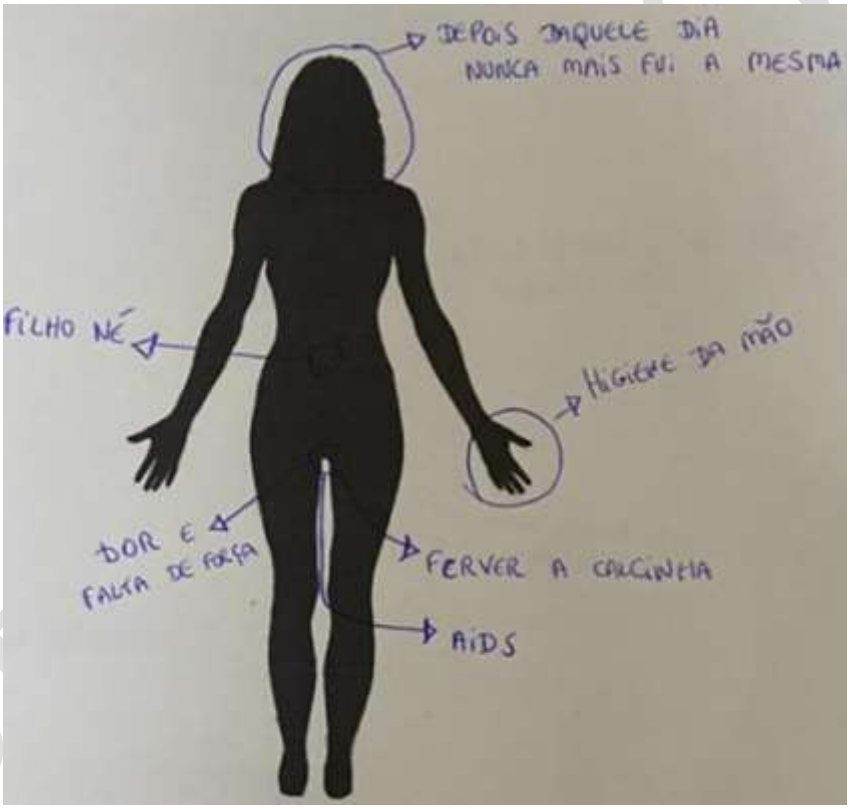

Figure 1 - Body Knowledge created by participant W7.

Thus, it is identified that the feelings of women about STI refers to issues of culpability, lack of knowledge about measures to prevent the disease, regret against not using protective methods, exclusion and judgment by family members and changes in personal life after having been contaminated by STI.

Women's experiences regarding sexually transmitted infections

The women also reported judgment and prejudice as common situations in their routines. In the testimonies, it is observed how these women were treated by family members, friends and society in general.

> It wasn't easy being seen as the one with AIDS by my family. (W1).
> My sister wouldn't even lend me her shorts anymore. (W3).
> I could see people commenting when I arrived at places (W5).
> I felt excluded from my friends. They saw me as the dirty one in the group. (W6).

Moreover, unprotected sexual practice permeated women's lives and was justified by the feeling of trust they had in their partners. Therefore, they considered that the existence of a fixed relationship represented a protective factor not to acquire ISTs. As evidenced by the figures chosen by participants W2, W4 and W5.

> Actually, who uses a condom with their husband, right? At least that's what I thought. (W1).
> For me, there was no reason for me to use a condom with my daughter's father, especially since he's very affectionate with me and her. (W2).
> I always thought there was no way I could catch these diseases [STIs], because I'm engaged, only if it were from a stranger. (W3).
> I trusted my husband. (W4).
> For me, the ones who should use condoms were gay men who make out with each other, but my husband was clean. (W5).
> In my mind, my husband was clean and took care of himself. That's why I didn't use condoms. (W6).

Images 2 - Images selected by participants W2, W4 and W5 in their almanacs. Source: Google Images (2020).

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Some participants, who were exposed to STIs, brought experiences related to puerperium. Feelings such as frustration were identified in the speeches of W3 and W5 for not being able to breastfeed their children, because they were informed that, due to STI, they could not experience this practice. In addition, it is noted that these feelings were present at the time the participants created their almanac and body know as evidenced below.

> Because I had this, this HPV, he [the healthcare professional] wouldn't let me breastfeed him [my son]. It hurt me. (W3).
> It was horrible for me. I was the only mother in my circle of friends who couldn't breastfeed. I felt useless. (W5).

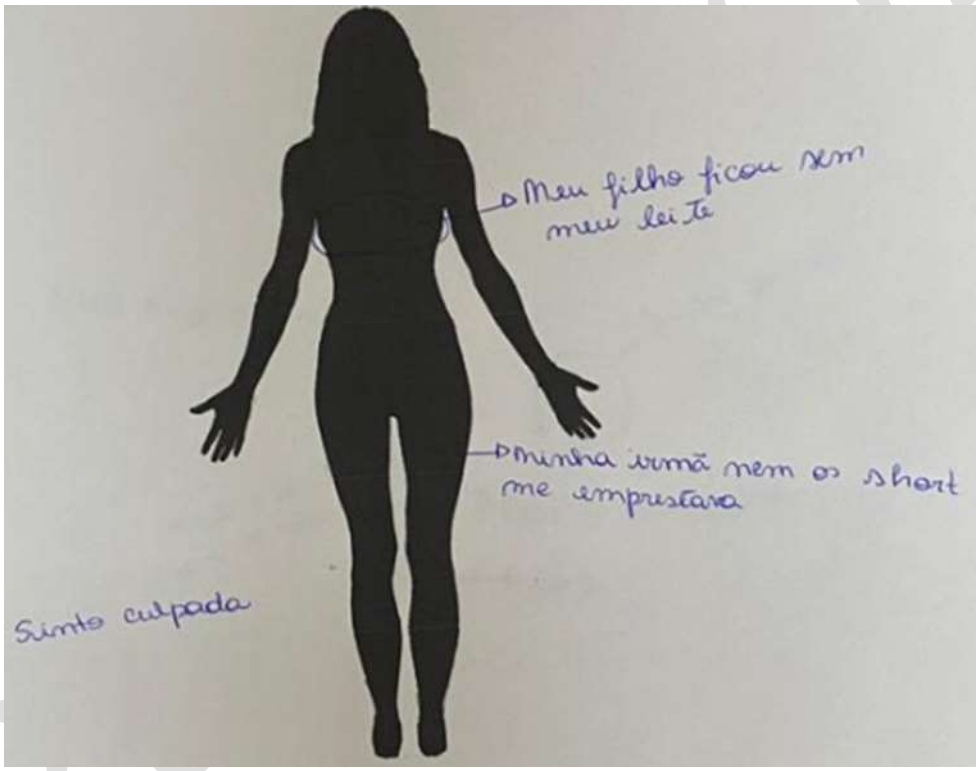

Figure 2 - Body of knowledge created by participant W3.

Images 3 – Images selected by participants W3 and W5 to compose their almanacs. Source: Google Images (2020)

Thus, it is identified that the experiences of women exposed to STI refer to issues of judgment and prejudice. Also the confidence in their husbands was a factor of risk exposure. They also brought negative experiences in relation to puerperium.

DISCUSSION

Regarding the age group of participants, a study conducted with women in Rio de Janeiro identified similar characteristics, since the population surveyed was in the age group from 25 to 44 years[16]. According to the 2022 HIV/AIDS Epidemiological Bulletin, there is a high incidence of HIV infections in women between 15 and 34 years old, which shows the need for public policies aimed at this public, not only for HIV, but also for other ISTs[9].

Furthermore, several factors assist in the characterization of women infected by STIs, such as poverty, incomplete high school education and increased cases among people with black and brown skin color. These conditions highlight the situations of vulnerability that women face, such as class, gender and race, being a condition intertwined in others[17].

Also, concerning marital status, a study found that 51.2% of women living with HIV are single. It can be seen that there is a fragility in strengthening love ties, which reflects the social stigma of prejudice, since the diagnosis of an STI in the female population is still, even if erroneously, linked to promiscuity. The perception of vulnerability to STIs is associated with a sense of security, especially among women who are married or in stable relationships. The trust in partners, built on the basis of coexistence and intimacy, causes many women to stop taking protective measures, believing that there is no risk of infection. However, this trust in the affective ties, although it seems a protective factor, puts them in situations of greater vulnerability towards ISTs[19].

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In relation to the STIs mentioned by the participants, a study conducted with women deprived of liberty showed a higher prevalence of HIV, followed by syphilis and hepatitis B. Although the studied population is different, the result partially corroborates what was found in this research. This may be due to the fact that women perform different sexual practices, in addition to the absence of the use of condoms or restricted access to them, contributing to the contagion of STIs in society[20].

The speeches revealed that the participants felt guilty and responsible for having contracted the infections. This finding corroborates the literature, which indicates that feelings of lack of control, guilt and irresponsibility are very common among women who receive a diagnosis of IST[19,21]. In the meantime, it is essential to highlight the feelings that are generated within these women, because internal attribution reflects on individual responsibility for an event that could be controlled. Such assignments are accompanied by an emotional and behavioral response of women. They usually show anger and negative behaviors[21]. Therefore, it is essential that health services are prepared to deal with these feelings and behaviors, without invalidating these emotions, as they are considered to have an impact on treatment adherence.

Corroborating these findings, the study outlines the importance of reception involving understanding and respect for the events and situations of internal vulnerability that these women experience. In addition, women have the right to be heard in their most intimate concerns, in a respectful and welcoming way, favoring the construction of bond that encourages their manifestations and makes it possible to detect the demands of the usuary[22].

Moreover, it is pertinent to highlight the participant who felt guilty for not having physical strength to avoid sexual violence, which ended up being infected by the HIV virus. Violence is recognized as a global phenomenon, capable of generating harmful social and health repercussions to women[23].

A systematic review on sexual violence in low- and middle-income countries identified warns about the importance of looking at this phenomenon in an expanded way, since there is no restriction on sex, age, ethnicity or social class to contract an STI[24]. Sexual violence is capable of generating feelings, as well as changes in sleep, guilt, judgment, impotence, discrimination, among other impacts, which remain throughout the woman's life[25]. When suffering this type of violence, women often have to deal with the diagnosis of STIs, thus being valid to point out that studies show a high prevalence of STI diagnosis after sexual violence[24-25].

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Given this, health professionals should invest in health education strategies in order to inform the population about the necessary behaviors after a possible exposure to STIs. In situations of sexual violence, victims may receive Post-Exposure Prophylaxis (PEP)[26]. In addition to this care, women have the right to psychological care and prevention of unwanted pregnancies, as well as adequate guidance on medical procedures and legal rights[26]. It is the responsibility of health services to offer singular care free from moral judgments. People exposed to STIs need timely reception and treatment.

Judgment and prejudice have always been linked to STIs, given the stigmas that perpetuate these health conditions. Similar to the findings of this manuscript, a study conducted in Uganda, West Africa, highlights issues such as humiliation, rumors, gossip and discrimination being experienced by participants after HIV diagnosis[27]. Furthermore, such situations trigger in individuals attitudes harmful to mental health, such as personal withdrawal, behavior change, hopelessness and despair for the feeling of non-belonging. Therefore, they begin to understand the need to lead a secret life, because if their families and communities know about the diagnosis, they can treat them differently,[28] as even pointed out by some participants.

It is also necessary to consider the consequences that stigma promotes in the lives of individuals exposed to STIs. Stigma can influence in several aspects, whether in the maintenance of treatment, as in love life, personal and interpersonal[29]. In addition, it is recognized the existence of two types of stigma, the decreed and the meaning. The stigma decreed is related to feelings of prejudice, discrimination and ill-treatment received after diagnosis. The stigma felt refers to the feeling of internalization of shame, guilt and fear that the user acquires throughout their experiences[28-29]. These aspects were highlighted by the study participants, because they deal both with the stigmatization resulting from prejudice against people living with STIs and with internalized judgment.

Another aspect that stood out in the findings of this research involved the rupture in women's confidence in relation to partners, since along with the diagnosis of STIs, they also had to deal with the discovery of an extramarital relationship. As the literature indicates, these situations are linked to the belief that fidelity is a resource for protecting couples. Thus, women often believe in the value of stable relationships and thus ignore the possibility of their partners experiencing affective relations with other people simultaneously[19,30].

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This context makes women vulnerable to exposure by STIs. This finding is consistent with a study that found that, when women are in stable relationships, they feel anchored to a protection group. In their ideal, the companions are not able to betray them, nor put them at risk[19]. However, parallel to these findings, systematic review diverges to point out that the participants were vulnerable to exposure to STIs, even though they are in stable relationships. Nevertheless, for various reasons, they did not use condoms in sexual relations. In some cases, simply because they did not want to[31].

Given the above, it is worth highlighting the importance of health promotion actions. They are considered to be able to raise awareness about the importance of condom use in all relationships, even in situations of marital stability[19]. Another situation mentioned by the participants involved the deprivation of breastfeeding. Before this, they expressed a feeling of frustration. It is inferred that the manifestation of this feeling is associated with the benefits of breastfeeding, widely publicized in society[31]. Therefore, faced with the impossibility of developing this practice, women may express negative feelings, since they may consider that, thus, they will not be able to develop motherhood fully.

This highlights the need for sensitive dialogue and active listening of these women. It is necessary to guide on the conditions that contraindicate breastfeeding, but at the same time rescue other strategies that will allow her to connect with the baby and experience his motherhood, without the negative feeling associated with the role of mother. In this respect, the research identified results similar to the screen study. In this, the participants expressed feelings of sadness, fear, frustration, self-contempt, denial of their own health condition, isolation and loneliness after being informed that they could not breast[32]. It was also found that feelings can prevail during the puerperal period, generating negative outcomes[32-33].

Therefore, the findings of the present study point out that pregnant women living with HIV often need to deal with the lack of information about their health condition. Therefore, many are unaware of the reasons that prevent them from breastfeeding, thus weakening their understanding and adherence to guidelines, and enhancing the feeling of guilt for not being able to provide breast milk to the baby[34].

This context reinforces the relevance of the professional's role in the reception and during prenatal care of women, who live with conditions that contraindicate breastfeeding. In these situations, the professional can act as a potential disseminator of information that contributes to the reduction of health problems. Moreover, constant professional updating is also necessary,

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which contributes to the correct orientation of users. It is necessary to do this addendum because, in the screen study, one of the participants reported that she stopped breastfeeding because she had HPV and, according to the guidance of a health professional, this condition contraindicated breastfeeding. Thus, a study carried out in the United Kingdom highlights a gap in health professionals' knowledge about HPV, especially when it comes to women exposed during pregnancy and puerperal[35].

It is also emphasized that there are few situations that partially or totally counter the supply of breast milk. Thus, breastfeeding is totally contraindicated in cases where the mother has HIV or human T-lymphotropic virus (HTLV) 1 and 2; when she uses antineoplastic drugs or radiopharmaceuticals; and when the child has galactosemia[36]. The situations that indicate against partial breastfeeding involve herpes infection, chickenpox, Chagas disease and drug use by the mother. It should also be noted that in conditions such as tuberculosis, leprosy, hepatitis B and C, and dengue fever, breastfeeding may be maintained[36].

Regarding the limitations of this study, it is believed that the pandemic scenario may have impacted on the recruitment of these women, since health services needed to reduce the number of visits to avoid crowding. Thus, new studies should be conducted to better understand the feelings and experiences of women exposed to STIs. In addition, the fact that the research was developed in only one municipality on the western border of RS was unable to represent the reality of other Brazilian regions.

Concerning the contributions of the study, it is inferred that the results may subsidize health professionals in the development of actions to promote care more consistent with the needs of women who experience exposure to STIs. Based on the findings of this study, it is also considered possible to assist and instigate health services about the need for improvements in sexual and reproductive health care and planning.

Furthermore, it signals the need for broader debates about STI, since the subject still represents a taboo in different areas of society. Therefore, the study is expected to promote reflections on the need for dissemination of information regarding the transmission, diagnosis and treatment of STIs in order to reduce the exposure of individuals and the spread of these infections.

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CONCLUSION

The feelings manifested by the women, after receiving a diagnosis of an STI, were guilt, sadness and anger. Regarding the experiences, it was shown the presence of situations of judgment and prejudice. In addition, they also emphasized issues of security in the conjugal relationship, since believing in their partners stopped using condoms. It was also contacted that the interruption of breastfeeding was a present issue in the experience of one of the participants.

There is a need to disseminate information about sexually transmitted infections in family conversation circles and in educational and health institutions, since it can be seen that most of the participants had incipient knowledge on the subject. Moreover, public bodies are responsible for creating health policies aimed at sharing knowledge related to sexual and reproductive health.

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