

Reducing Vulnerability to HIV/AIDS among Mature Women in a Large City of Brazil: The Role of Communication¹

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Abstract

Social Communication is a science that plays a role in the prevention and treatment of Human Immunodeficiency Virus (HIV)/Acquired Immune Deficiency Syndrome (AIDS) by disseminating correct and up-to-date information, as well as by acting in the cultural and symbolic questions that surrounds the relations between human beings. The feminization of AIDS and growing rates of infection of mature women (50+) raise necessity to understand the singularities of this group so that future public policies and communicational campaigns can be effective and lead to the decrease of their infection rate. This paper brings a Communication Diagnosis focusing on mature women, which contains demographic analysis, in depth interview, descriptions of public policies and campaigns, besides literature review.

Keywords: Communications for public health; diagnosis in strategic planning, population aging, feminization of HIV/AIDS; HIV/AIDS.

1 - Introduction

The first reported cases of Human Immunodeficiency Virus (HIV)/Acquired Immune Deficiency Syndrome (AIDS) in Brazil date from the 1980s. Throughout the last two decades, substantial changes in the profile of those infected and in the main forms of infection have occurred. In the beginning, the majority of cases referred to men, mainly those who had sex with other men and living in large urban areas. Since the mid 1990s, however, a great and fast dissemination of the cases of HIV/AIDS among women (the so-called feminization of the epidemic), has been observed. More recently, women in unions and over 50 years of age have had the highest rates of infection.

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cultural and symbolic questions that surrounds the relations between human beings. In Brazil, campaigns to stimulate the prevention of HIV have always concentrated on youngsters, homosexuals, and men. Only very recently have they targeted mature women – those 50 years-old and above.

This paper focuses on mature women in the city of Belo Horizonte, the state capital of Minas Gerais, Brazil, and the fifth largest city of the country. The objective is twofold. First, we aim at discovering how vulnerable to HIV/AIDS mature women perceive themselves to be. Second, we verify how they perceive the strategies of communication and public health towards HIV prevention, whether they recognize themselves in the campaigns, and which communication and public health strategies would be more effective in dealing with them. Data comes from “Saúde Reprodutiva, Sexualidade, Raça e Cor” - SRSR (Reproductive Health, Sexuality and Race/Skin Color), a survey conducted in 2002, as well as 11 in-depth interviews with mature women in 2004. The analysis, called Diagnosis, also includes descriptions of campaigns and public policies targeting mature women.

2 - Literature review⁵

Analyzing the question of social vulnerability and the evolution of the epidemics in the cities of Southeastern and Northeast Brazil, Barbosa and Sawyer (2003) pointed out the importance of including macro-social as well as individual variables in the studies about vulnerability to HIV/AIDS. According to them, the studies that adopt such strategies are capable of efficiently assisting the proposal of public policies that aim at reaching the most vulnerable segments of population.

With ample theoretical basement, the work of Silva and Paiva 2008 classifies vulnerability in three interdependent levels: individual vulnerability (related to cognitive and personal behavior), social vulnerability (related to social context) and programmatic vulnerability, which are mainly Public policies, such as the “Programa Nacional de Combate à AIDS”, implemented by the Brazilian Federal Government (Ayres, 2003 in Silva and Paiva, 2008).

Ayres et al. (1999: 57) had previously defined individual vulnerability:

- Every individual is, in some degree, vulnerable to the infection of HIV, but consequences and vulnerability can vary throughout the time in function of values and resources that allow the person to find ways of self-protection.

⁵ Authors translated all quotes and titles.

- Individuals infected with HIV are vulnerable to diseases, impairment, or death in an inverse function to the social support and assistance that they get.

- The conditions that affect the individual vulnerability are cognitive (information, awareness of the problem, and awareness of ways to face it), behavioral (interest and ability to transform attitudes) and social (access to resources and power).

2.2 - Public Relations and Public Health Communications

In our society we supply our necessities direct or indirectly by governmental and private organizations. Social interaction is the base for the functioning of the organizations. Science of Communications has an important role in this process, for propitiating transparency and dialogue between these organizations and their audiences (Kunsch, 1986). Globally, the necessity of strategically planned communication started with the emergency and consolidation of modern life brought by democratic and capitalist regimes (when competition made institutions begin to care for their relations with their public).

The growing need for strategic communication is also associated with the beginning of the activity of Public Relations (Simeone and Mafra 2007). According to Margarida Kunsch (1986), the purpose of hiring a Public Relations in the organization (public or private) is to ensure credibility with their social actors – here defined as the variety of human resources with which the organization deals day after day, such as employees, managers, clients, suppliers. By means of planning and using appropriate techniques, it is possible to understand the difficulties and challenges faced by each social agent regarding the organization as a whole, and consider actions to develop a good relationship with the public and reach a common objective.

Attentive of the social relevance of HIV/AIDS and the aggravating demands on the public health system, it is possible to think about the social function of Public Relations. The main goal is to intercede positively by means of planning communication, in the direction of awaking and promoting the conscience about vulnerability of mature women and the necessity of an organized action to control it. “Communication, planned from an ethical horizon, starts to be one of the main instruments to assist the movement in its process of transformation of reality” (Braga et al.; 2002, p. 15).

The tools of communication planning are already widely used by managers in charge of public health even without theoretical knowledge because they produce significant results once they are in specific contexts. A good example is the frequent use of strategies of

communication by the Health Department in Belo Horizonte in campaigns against the advance of dengue, a tropical disease whose host is a mosquito. Sound cars, pamphlet distribution, radio spots, television publicity, and other long period actions, such as the Communitarian Agents of Health who periodically go door-to-door to talk and teach incisively the same message, however for a distinct public: the message that co-responsibility is the key to prevention.

In the digital magazine "Comunicação & Saúde" (Vol. 2, nº3, December of 2005), Archimedes Pessoni, published an interview presenting Communication and Health as a growing field of studies and research. According to Pessoni, at the time of the interview, about 80 types of research in 48 groups were studying the subject. He quotes Holtgrave Mailbach who explains that Communication and Health is "the use of the communication techniques and technologies to (positively) influence individuals, populations and organizations with the intention of promoting conditions planned for the health of human beings and environment". Coe Glory adds that it is "a process to socially offer persuasive, interesting, educative and attractive information that results in healthy individual behaviors". Luis Ramiro Beltran states that communication "is a mechanism of intervention to generate, in multiple scales, social influence that provides knowledge and attitudes leading to the care of public health".

A great challenge of this growing field is to expand the limited notion of health. "To make proper citizens exceed an individual vision of health - based in the illness and its individual initiatives to fight it - to understand health questions relatively to the collective body (Simeone and Mafra, 2007 p. 6)".

Instead of taking care of medical and palliative issues, Communication intends to promote the idea that people should deal with health in the social sphere of prevention.

The Secretary of Health of Belo Horizonte, the organization responsible for the detection, treatment and action of prevention of HIV/AIDS in Belo Horizonte, can count with the efforts of Public Relations to get to know its public and develop effective actions of health promotion. These efforts are called *Planejamento Estratégico da Comunicação* (Strategic Planning of the Communication), and they aim to reduce the vulnerability of mature women to HIV/AIDS, as strongly suggested in the research *Comparação dos Perfis e Percepções de Vulnerabilidade de Mulheres Brancas e Negras HIV/AIDS em Belo Horizonte e Recife* (2007).

The Strategic Planning of Communication, created by Margarida Kunsch, contains many steps – from defining the problem to evaluating the results after implementing the program. The most important step is the Diagnosis, and this is what this paper proposes to do.

In this case, the diagnosis serves to reveal who these mature women are, how they see themselves facing the possibility of an infection, and what they expect from the campaigns and strategies prepared by the Secretary of Health of the city of Belo Horizonte – so that we may improve future campaigning. Not only are the women in focus, but also the social agents such as the governments and the sexual partners of these women. We aggregate qualitative and quantitative analyses, as well as an assessment of public policies, communication campaigns and actions made by NGO's to describe the existing efforts to prevent and treat the spread of HIV/AIDS among mature women.

We expect many results once our suggestions are put into practice. First, to increase investments in prevention campaigns to make possible the early detection of the virus. Second, to incentivize treatment (which is free of charge in Brazil). Third and most important: to empower women, so they can advocate for themselves and have the social-economical and psychological conditions to make their own decisions, including the usage of condoms with their sexual partners. Only then, we will be able to reduce the numbers.

2.3 – Some factors correlated to vulnerability

This project belongs to a bigger project funded by UNESCO/Ministry of Health, entitled *Comparação dos Perfis e Percepções de Vulnerabilidade ao HIV/AIDS de Mulheres Brancas e Negras em Belo Horizonte e Recife* (Comparison of the profiles and perceptions of vulnerability of black+brown and white women to HIV/AIDS in Belo Horizonte and Recife), which investigated women between 18 and 59 years in two major Brazilian cities. In this sub-project, we focused only on women between 50 and 59 years old in Belo Horizonte – known as mature women -, comparing blacks and whites. The objective of the literature review was to analyze factors mentioned in the literature that are possibly related to the vulnerability of women such as race/color, marital status, age, education (which is a proxy of income) and socio-cultural and behavior, trying to identify social, economic, and demographic characteristics associated to situations of vulnerability in Belo Horizonte, MG.

Age

Regarding age, according to the research *Vulnerabilidade ao HIV/AIDS entre homens e mulheres com mais de 50 anos* (Silva and Paiva 2008), the increasing infection among individuals of this age band or older can be explained, in part, by cultural changes on sexuality and increasing life expectancy (including those of HIV-positives due to the greater access to antiretroviral therapy) (Santos et al 1997 in Silva and Paiva 2008). Moreover, pharmaceutical advances favor the performance and sexual quality through medicines that facilitate and maintain erection and hormonal replacement, improving self-esteem and contributing to the occurrence of sexual relations.

“Data from the Health Department [of Brazil], regarding the behavior of sexually active Brazilians, showed that 17.3% of the interviewees who were at least 50 years old at the time of the interview had about 6.3 sexual intercoursures per month, in the last 6 (six) months, approaching, thus, the average of 9.2 of the population between 40 and 49 years old” (BRAZIL, 2003 in Silva and Paiva 2008 P. 2). However, the improvements in the sexual performance did not come together with an incentive to the practice of safe sex for mature people.

Obstacles, such as difficulty of wearing a condom, the idea that condoms are for promiscuous sex, sterilization, or menopause in women aged 50 or more, can also lead these people to reject the consistent use of condoms. The research also shows that health professionals do not consider that older people are susceptible to the risk, thus they do not talk about sex and do not offer the HIV exam to individuals in this age group. (Azambuja, 2000 in Silva and Paiva, 2008). Beyond environmental factors, biological characteristics also play a role in the vulnerability of mature women. The natural process of aging which causes vaginal dryness, reduction of elasticity and secretions, and fissures in the vaginal walls are situations that favor infection of HIV during sexual intercoursures. The morphology, associated with the absence of the perception of risk, can lead a larger number of aged women to the epidemic of HIV. Particularly, because some women are no longer in their reproductive years, they are no longer concerned with the contraceptive quality of the condom (De Carlo 1998).

The elderly are even more susceptible to opportunistic infections, so if they fall ill, they tend to die faster. Moreover, treatments against HIV can interfere with treatments of other chronic illnesses already presented by the patient. (De Carlo 1998).

According to the research *¿Qué necesitan los mayores de 50 años para la prevención del VIH?* (1998), about 10% of the new cases of AIDS in the U.S. occur with people aged 50 or more. Many are infected earlier, but come to discover that they are HIV positive in advanced age when they develop opportunistic illnesses. Moreover, it can be a disturbing situation to ask about sex or drugs to physicians and nurses. Mature people may not feel comfortable in support groups either. These arguments help to propagate the idea that mature adults and elderly do not have sex. Clearly, these are the reasons why campaigns never focus on them.

Muy pocas campañas de prevención son dirigidas a personas mayores, y en la mayoría de los anuncios con mensajes educativos no aparecen personas mayores, lo cual les convierte en una población a riesgo e invisible. Esto ocasiona que las personas mayores estén generalmente menos informadas sobre el VIH que los más jóvenes y menos conscientes de como protegerse a si mismos de la infección (De Carlo P., 1998, p. 1).

Experiences with programs in Florida have proven to be beneficial and efficient at instructing this population. Other efforts, such as to include aged characters in the media campaigns, and to stimulate HIV testing also are important. (De Carlo, P. 1998).

Sex and gender

When analyzing the differentials between sex and gender, we perceive that heterosexuality and virginity at marriage are protection factors according to women. Yet men believe that age is the protection factor, and the main situations of vulnerability are “the use of drugs, the reliability in sexual partner, the difficulty to use condoms when in a steady relationship, sexual intercourse with prostitutes and the participation in orgies” (Silva and Paiva 2008). Women tend to think that they are more vulnerable due to a biological and a social reason - the viral load in the semen is greater than that in the vagina, and they have greater difficulty to negotiate the use of the condom with the partner. Men think they are more susceptible when they cannot resist a sexual invitation, when they use drugs, when they are homosexuals, or when they do not use condoms.

In general, they both perceive the vulnerability in others rather than themselves. For that reason, the interviewees recognize the necessity of condoms, but they do not use it,

especially due to love, passion, and the belief that sexual intercourse with a wife/husband is not dangerous. In addition, women delegate their desires and responsibility of protection to men.

The paper “Comparison of Profiles and Perceptions of Vulnerability of Black+Brown and White Women to the HIV/AIDS in Belo Horizonte and Recife” used the method Grade of Membership (GoM) to generate four groups of women with different profiles of vulnerability. Looking at women aged 18 to 59, the researchers discovered that there are still many barriers for safe sex. The main barriers are the incapability of negotiation and the assurance of the heterosexuality of the sexual partner (Miranda-Ribeiro et al, 2009a).

They also observed that some groups do not value virginity and do not tie sex to marriage. Many women report to have made decisions regarding sexual behavior playing the role of a naïve-character, innocent, and silly, according to what the male expects the female role to be – contrary to the masculine role of “knowing how things work.” Many still believe that the taste for adventure is a masculine characteristic, and women who “have desires” are vulgar.

In spite of their higher risk of infections, some women still believe that the responsibility of protection belongs to men, together with the option of having as many sexual partners as he wants/needs. This type of behavior, coming from the women, is clearly associated with vulnerability; however, it is difficult to measure that quantitatively.

Miranda-Ribeiro et al (2009a) also confirmed old information, such as the difficulties in the access to contraceptives (condoms are expensive), and the refusal to wearing a condom due to fear of losing an erection. They also found new information, such as the use of condoms to keep the hygiene, in case of “dirtiness” on the penis. Women continue to refuse using condoms for oral sex, even those who mentioned this type of act as a possible source of STI’s (sexually transmitted infections). Many women still say that if they were to ask their partners to use condom, the latter would think they were cheating on them, especially if another contraceptive method was already in use. “A real man does not use a condom, particularly if he is married”, and “a woman who carries condoms in her purse is promiscuous” are two very common thoughts.

Thus, the majority of the interviewees consider condoms as totally dispensable in a relationship where trust is involved, such as marriage. However, most of them assume that cheating is a reality. The feeling of love and commitment functions as a vaccine for the

HIV/AIDS infection and makes the danger of AIDS seem more distant. Miranda-Ribeiro et al (2009a) enumerate four conclusions regarding the subject:

- Knowing that condoms are necessary does not imply the use of them;
- Knowing that cheating is a possibility does not imply the use of condoms with the partner;
- Knowing that the partner is unfaithful does not imply the use of condoms with him/her; and
- Knowing about the existence of STI's and HIV does not imply one seeing herself as a vulnerable to being infected independent of the sexual and protective behavior that one assumes.

In this sense, even though some studies reveal high level of knowledge about the forms of transmission of HIV/AIDS, this does not assure that women are capable, as much as men are, to negotiate the use of condom, confirming the inequality between genders. This is even worse in older women (Fernandes et al 2000; Ferreira 2003).

Marital Status

The research *O significado de fidelidade e as estratégias para prevenção da AIDS entre homens casados* (Meaning of Fidelity and Strategies of Preventions of AIDS among Married Men) investigated the masculine infidelity and the consistent use of condom as a strategy of risk reduction and prevention of HIV/AIDS (Silva 2002). In a few words, it is natural for males not to have the wife as the only sexual partner. However, the men understood these strategies of self-protection – the use of condom in extramarital relations – to be a respectful action towards the wife.

Using condom with the wife could make her suspicious of infidelity, unless it is used as a contraceptive method (Silva 2002).

The scarce availability and capacity for safe sex added to a complex tram of norms and values, stereotypes, relations of power, feelings (affection, love and revenge) and meanings (i.e that the condom is not for the marriage). Thus, it seems evident that the cultural law that define masculine sexuality as unrestrained (man cannot refuse chances of sexual contact) and/or claim that running risks is an essential element of masculinity conspire seriously against the capacity of men of self-protecting and protecting their sexual partners (SILVA, p. 42, 2002).

Thus, masculine sexuality is one, if not the main element to be focused on when preventing the spread of HIV among women.

According to the men interviewed, sex itself is not a betrayal, but serves to spice up the routine when one has had a wife for a certain time. However, when these men get to know their extramarital partners well (or due to another reasons not mentioned by the authors), they disrespect the rule of condom and stop taking care of safety in extramarital relationships, making them vulnerable to their own infection and the infection of their spouses.

Quiroga (2006) tried to understand how individuals establish negotiation and preventive behavior, emphasizing the influence of gender and race in the composition of a union. Through 40 in-depth interviews with men and women from a slum in Belo Horizonte, she noticed that there is strong influence of gender relations in sexual negotiation, and some influence of race/color.

Quiroga's study found that conversations about contraception are more frequent than about diseases. The use of condoms is can be related to: a) dissatisfaction regarding side effects on birth control pills, b) being on a waiting list to obtain female sterilization procedure, c) to eventual use when the regular adopted method is unavailable or when the original method was causing harm to the female body, d) in the occasion of error or discontinuity in the use of the main method, e) for the combined use with birth control pills in the fertile period, and f) to prevent "dirtiness" in the intercourse during the menstrual period. No interviewee affirmed to use the condom systematically or consistently to prevent STIs. The author also found that women have the desire to use condoms to prevent vaginal infections - one request that the male partner never accepts. They fear the demand could be understood as a declaration of betrayal (Quiroga 2006). The results suggest that the HIV testing should be offered more often, besides during prenatal care and the blood donation bank (so far the only places where the patient is not stigmatized for being tested).

Race/color

Black women are more susceptible to HIV for not finding, or having greater difficulty to find, strategies of self-protection (Lopes 2003). Black women also die more of AIDS than whites, due to the "delay in the diagnosis of the black patients, which is related to lower perception of risk (...) that still associates AIDS to the image of white middle class homosexuals , and the greater difficulty of black women in negotiating safer sexual

intercourse coming from the low social status that she has” (Batista, 2002 in Quiroga, 2006 p. 3).

SRSR data indicate that White women in Belo Horizonte and Recife are more likely to have more schooling, health insurance, a stable sexual partner in the previous year, and more power to negotiate condom use. Blacks and Browns in Belo Horizonte, on the contrary, are more likely to have low education, to use the public health system, and to feel disempowered regarding condom use (Miranda-Ribeiro et al, 2009b).

Socioeconomic and psychosocial conditions

Ferreira (1998) distributed the Brazilian population according to vulnerability levels, and the majority of the elderly are in the most vulnerable group. About 50% of this group had never used condoms, and among the ones who have used, 84.9% did not use them consistently. Moreover, a big proportion of the Brazilian population did not have enough information about forms of transmission of HIV in the year of the research. Information level increases in the same proportion of improvements in socioeconomic conditions.

The socioeconomic profile of the elderly suggests that they are vulnerable not only to aspects related to understanding their own risk of infection, but also, or mainly, to poverty. Barbosa & Sawyer (2003) for example, show that people who live in areas where the access to mass communication is restricted present major vulnerability to HIV. They have the lowest values of per capita income, the lowest percentages of expenses spent towards health and sanitation, the smallest percentile of doctors per thousand inhabitants, the highest rates of infant mortality, the biggest wage inequality between men and women, and the worst indexes of quality of life.

According to Fernandes (1994), the opening of spaces for reflection is important, because it favors a major perception about HIV, which influences the consistent use of condoms. There are, however, four types of perception: the perception of severity or gravity, the perception of the susceptibility (possibility at acquiring the infection); perception of utility (the benefits that the modification of habits could cause), and the perception of cost (that is, the inconveniences and problems that this modification of habits can cause).

Vulnerability also has consequence on the confrontation of the illness. Fernandes (1994) enumerates three types of attitudes regarding HIV/AIDS infection: (1) the transference of the problem (refusal), (2) the visualization of the problem (that is, the

perception of the susceptibility and severity, which “sometimes starts with the first contact with a sick person, the regular conversation with a colleague or by the knowledge about the types of infections (...). At this moment, the panic appears frequently and emerges its associations with questions about death, sexuality and punishment” (1994, P. 177), and (3) the demystification and acceptance of the reality (where the personal strategies of prevention are traced).

2.4 - HIV/AIDS in Belo Horizonte

Changes observed in the epidemics of AIDS in Belo Horizonte are like those of Brazil. Throughout the years, there was an increase in heterosexual transmission, feminization and pauperization of the illness. The characteristic of feminization is the alteration of infection in the ratio of man/woman, which varied from 42:1, at the beginning of the 80's, to 2:1, in recent years. Regarding the category of exposition, heterosexual transmission increased and homo-bisexual exposition decreased (from 82% of the cases in the end of the 80's, to 37% in the end of the 90's). The category IDU (Intravenous Drug Users) decreased from 15% to 7% during the 1990's.

3 - Methods

In order to discover which communicational strategies would reach the female mature public to prevent the spread of HIV, we first have to find out who these women are.

In the first part of the diagnosis, we analyzed a sample of 170 black+brown and white mature women, between 50 and 59 years old, interviewed by the SRSR survey in 2002. In this analysis, it was also possible to evaluate the lack of information on HIV/AIDS, forms of infections and treatment, and identify the socioeconomic and demographic characteristics associated with situations of major vulnerability. Moreover, we investigated how these women perceive themselves vulnerable to the infection.

In the second part of the research, to further understand the specificities of these women and their opinions on the subject, we analyzed 11 semi-structured interviews, borrowed from the project “Comparação dos perfis e percepções de vulnerabilidade de mulheres negras e brancas ao HIV/AIDS em Belo Horizonte e Recife”, developed by Cedeplar/UFMG and funded by the Ministry of Health/UNESCO. The information gathered in the qualitative interviews is of great importance because they allow us to perceive what the

women consider effective in terms of communication on HIV/AIDS. The questions analyzed focused on the following subjects: Impacts and influences of AIDS on decisions regarding life, sexual behavior, choice of partners, sexual experiences; the use of condoms; the perceptions of risk and representations of the illness in the family, religion, school, media, friends, partners; the role of the media in the perception/invisibility of HIV/AIDS and the situations of risk, advices for prevention; suggestions for campaigns (more efficient language, mechanisms, medias); characteristics that must be considered in the elaboration of campaigns for stronger efficiency when it comes to gender, race, social class, education level, and marital status.

In order to transform these findings and suggestions into effective strategies, , the third part of the diagnosis intended to research the services and public policies regarding prevention and assistance that are already offered by the Federal Government, the Government of the State of Minas Gerais, the Municipal Government of Belo Horizonte and Non Governmental Organizations from the same city. We interviewed and visited the Communication Departments as a way to collect information and pieces of campaigns.

The fourth part of this paper deals with all the campaigns ever made to stop the spread of the infection of HIV/AIDS in Belo Horizonte, with focus on women or mature women. These were described, illustrated and briefly analyzed. In its majority, they were national campaigns produced by the Ministry of Health of Brazil and locally broadcasted.

3.1 - Panorama of the Vulnerability of Black+Brown and White Women aged 50 to 59, Living in Belo Horizonte, to HIV/AIDS Infection

3.1.1 –Description of variables

To accomplish the analysis, we manipulated the SRSR 2002 database and dropped every women younger than 50 years old and kept only the ones who were inhabitants of the city of Belo Horizonte⁶. Black and brown women formed the category “negra”. Beyond the whites and “negras”, no other race/color was considered in the analysis, such as yellow and indigenous, or women who had not answered this question.

It is statistically incorrect to draw conclusions on vulnerability, since no cultural and environmental conditions had been evaluated, such as exposition to domestic violence, type of residence, and other possible sources of race/color and gender inequalities. Moreover, we

⁶ The survey was conducted in Belo Horizonte (MG) and Recife (PE).

did not make any test to check the correlation among variables. This analysis intends to be merely descriptive.

Socioeconomic variables were: years of study, number of bathrooms or sanitary installations in the household, material of the roof, marital status, participation in labor market in the previous week, health insurance, current religion, type of household, household income (in minimum wages - minimum wage 2002 = R\$200,00), women's gross income (in minimum wages - minimum wage 2002 = R\$200,00) and parity.

Exactly 170 women aged 50 to 59 compose the sample, 51.8% being White and 48.2% being Black or Brown. Married women are 55.6% of the sample, and the percentage of widows who are Black is almost twice the percentage of widows who are White.

The great majority, 77.5%, live in their own property. The percentage of types of property per race/color is practically similar between Blacks and Whites, except for the fact that Whites tend to have the property already paid while blacks are still paying for it.

Regarding years of education, 56.8% of Whites had more than 11 years of study, compared to 28% among Blacks. When analyzing the category 1-3 years of education (close to being illiterate), we found 11.1% among Whites, compared to 24% among Blacks. Therefore, regarding education, Whites are in a better situation if compared to Blacks+Browns.

In general, 82.2% of the interviewees had worked or done activities (paid or not) in the week of the research. Among these, 42.3% declared to have some income proceeding from this activity, whereas 57.6% of the women did not work or had income equal to zero, and little more than 18% had income of up to two minimum wages. 13.5% of Whites and only 6.2% of Blacks had had an income of more than four minimum wages. However, when observing the total income of the household (where other people contribute for the total income), 63.2% of Whites and 41.5% of Blacks start to have an income equal to or bigger than four minimum wages, which means that the women's income does not have great participation in the total income of the household.

According to the analysis, 62.3% of the sample is Catholic. It is interesting that 10.2% of the Whites declared themselves without religion compared to 2.4% among Blacks+Browns. For those who declared themselves as Pentecostals, there were three times more Blacks than Whites.

The number of women with health insurance is greater among Whites than Blacks – 65.5% and 46.9% respectively.

The average parity is also a little higher for Blacks (3.52), while for the Whites the number is 3.15.

The percentage of the sample who have entered menopause is 85.7%.

Which women need to be focus of action and campaigns? Technically, anyone who does not demonstrate total knowledge on HIV/AIDS and/or does not make consistent use of condoms. It does not matter if they are married or single.

Women who did not spontaneously mention AIDS as an illness are 29% of the sample, independent of color/race. According to the analysis, 5.9% of the sample believed that there is a cure for AIDS and 9.4% did not know that the Brazilian Government pays for the treatment. On the contrary, 4.2% believed that there was no control for AIDS. Believing in the cure or being unaware of the existence of treatment represents vulnerable situations, because it means they do not worry about prevention or they can refuse testing because they do not know there is treatment.

The great majority of the women of the sample (78.8%) have never undergone a test for HIV/AIDS infection. Only 13.5% did, usually more than one year before the survey. Unfortunately, there is no way to know if women were tested while receiving prenatal care which is mandated for every woman receiving prenatal care.

One of the most subjective questions of the survey is whether their personal risk to getting infected by HIV is great, moderate, small or inexistent. According to 59.4% of the women, they have no risk at all to be infected and the number rises to 69.5% among Blacks.

Lack of negotiating power also reflects vulnerability. The expression symbolizes the capacity to interrupt a sexual intercourse with the most recent partner if he refused to wear condom. Data shows that 65.3% feel certain that they can be successful in stopping the intercourse, 8.24% some certainty, but 22.9% would not even try to stop intercourse.

Considering vulnerability, the fact of not having used a condom with the last partner, stable or not, independently of marital status: 55.3% of the sample did not use condoms consistently, compared to 7.1% who did use condoms. The most relevant explanation (or excuse) for not using condoms is the fact of being married or having a stable partner.

Among the women who are not on birth control, the most cited reason for not using condoms was menopause (16.1%), followed by abstinence - voluntary or not - (6.5%) and female sterilization (4.8%).

3.1.2 – Tables

See attachment

3.2 – In-depth Interviews

Eleven in-depth, semi-structured, interviews were analyzed (White and Black+Brown women, without distinction, inhabitants of Belo Horizonte). Although the ages of these women are unknown, they all belong to profile 2 of the GoM made by the research *Comparação dos Perfis e percepções de vulnerabilidade de mulheres brancas e negras ao HIV/AIDS em Belo Horizonte e Recife* (2007). Profile 2 has the largest probability of having women above the age of 40, the oldest age group in the research. They also have more probability of being separated, widowers, with less education (0 to 7 years of education), in addition to having three children or more.

In this analysis, we searched the dialogues looking for reasons why women fail to use condoms (or reasons why they use it), that is, their beliefs which intervene with the use of condoms. We also looked for points related to unfamiliarity and disinformation about the illness, which cause them to be vulnerable. We also focused on sources of information and campaigns the government should establish, so women could see themselves as actors. Moreover, we searched for possible behaviors in case of having an infected partner.

The sample does not represent the opinion of every 50 to 59 year old woman in Belo Horizonte. This, however, does not exclude the scientific characteristic of in-depth interviews, since the major objective is to learn more about a few subjects, without generalization for the total population. It is important to say that we did not exhaust all the elements; only highlighted what we believed to be more important for this diagnosis.

The names of the interviewees are fictional, to preserve their identity.

A – Knowledge found in the discourse of the interviewees (examples):

*** A condom is to be used until the moment when the relationship gets serious, stable and a pact of mutual trust is established.**

INTERVIEWER: What about your first husband, did he use condoms with you?

MARGARIDA: No, never.

INTERVIEWER: And the second?

MARGARIDA: Yes.

INTERVIEWER: Because he wanted or because you requested?

MARGARIDA: No, I requested. He used the whole time, but when we got tested and after some time together, when we knew we were just us, then we did not wear anymore.

INTERVIEWER: So, after the formalization of the union you never requested condom and he never used it?

MARGARIDA: We were abandoning the habit, it was just about us. I knew it could be risky and we still do the tests, except HIV, this one I did just when I was pregnant.

*** Requesting condom in a stable relationship questions fidelity**

VIOLETA: First I will ask him why. Because if he is now requesting a condom it means he is suspicious of something. Then I want to know why. Because we never used condom and suddenly he wants is?

*** In extra-marital relationship, people are expected to use condom with the “other” partner.**

INTERVIEWER: Would you forgive him?

AÇUCENA: I would.

INTERVIEWER: Even if he had sex with somebody?

AÇUCENA: I would.

INTERVIEWER: Would you forgive even if he had sex with other people without condom?

AÇUCENA: Yes, independently.

INTERVIEWER: Would it make a difference if he had used condom?

AÇUCENA: Yes, because I would be more tranquil.

INTERVIEWER: What do you think about the following quote: “man is naturally unfaithful”.

AÇUCENA: (laughing). I agree. That is true.

INTERVIEWER: What about women? Are there many women at your age who are unfaithful too?

AÇUCENA: Yes, lots. Every day I hear about someone.

INTERVIEWER: How are their stories? How do they “pay them back”?

AÇUCENA: Oh, sometimes they have sex with the neighbors. (laughing)

INTERVIEWER: Is it? Is it easy to pay the husband back?

AÇUCENA: Yes, they think it is pretty easy.

INTERVIEWER: And how is it? How do they take care of themselves?

AÇUCENA: They do.

INTERVIEWER: How?

AÇUCENA: With condom, but not every one of them.

INTERVIEWER: No?

*** Even after being cheated, they keep on having sex without condoms with the stable partner.**

INTERVIEWER: So you think he has had an affair?

AÇUCENA: Yes, definitely.

INTERVIEWER: Definitely?

AÇUCENA: I found out.

INTERVIEWER: In this situation, what happens when he searches for you in bed to have sex? Let’s suppose he has had an affair and then wants to have sex with you at home. How is your situation at this time?

AÇUCENA: Ah, there are times when I do not accept. I have to be very prepared to accept him.

INTERVIEWER: And how do you accept him?

AÇUCENA: Ah, I accept when I feel I am doing well. If I don’t have the will, I don’t have sex with him.

INTERVIEWER: But then you request condom?

AÇUCENA: Yes. And that is the moment.

INTERVIEWER: So there is a right moment to request the condom?

AÇUCENA: yes! And I do request! But then he starts speaking and he ends up convincing me.

INTERVIEWER: Convincing you that you should not wear condom?

AÇUCENA: Yes, that there is no necessity and so ever. And then one day I said: Look, if I get infected with anything, I will kill you (laughing). I always say that to him.

*** Cold relationship could be a sign that the partner is in love with somebody else**

INTERVIEWER: Imagine. This is just a hypothesis: you are having a relationship with somebody for some time. And then you realize that the person is not looking for you for sex anymore. What do you think is going on?

ACÁCIA: Well, [**]. With my husband... this happened to me. If my husband does not want to have sex with me or have a relationship, I would think he has another woman.

INTERVIEWER: So you think sex is fundamental and when there is no more sex...

ACÁCIA: It means he is in love with somebody else. This is what I think.

*** If the person looks clean, there is no need for condom.**

INTERVIEWER: For example, when we look at a man does the fact of him being clean or dirty influences the women asking him to wear condom?

ACÁCIA: Influences a lot. Sometimes she says: “he is so clean, I think there is no need for condom”

*** Opposite view: Women should trust no one**

ACÁCIA: I think it is easier for the women to talk about sex and methods [contraceptives] with her husband nowadays. Especially because raising a child is very difficult, education is very difficult. Secondly, because if she does not use condom or any method, she runs the risk of getting a disease from the man. I don't trust men [*] my husband, what he meant to me, I never trusted him. I was right because he even found another person!

B – About the campaigns

*** Campaigns do not teach the use of condoms; they just talk about how important it is to use it.**

MARGARIDA: It was just in the hospital, I am telling you. They say: “let's take care, everybody, let's use condoms not to get AIDS”, but they never explain how. Some people say there is a cure for AIDS, but there is not, there has never been. Sometimes I see on TV, or take some time off to read the newspaper and get informed, but they spend so much money [probably on publicity], but never do the right thing. They talk about health, but never get to the point, you know.

*** Sources of information on HIV/AIDS: public health clinics, lectures, family, school, television, laboratories, libraries, books, tapes, newspaper, friends, health, health agents.**

INTERVIEWER: Do you think there is enough publicity about HIV/AIDS or there should be more?

ROSA: No. There should be a lot more.

INTERVIEWER: And where should it be showing?

ROSA: TV, clinics. Plus, you have to go find your own piece of information, which is lacking. Some people don't go. There's been a long time since I last went. Newspaper, too.

INTERVIEWER: Who do you think that has more possibility of getting informed about AIDS?

PENHA: We do, women, right? Because we inform each other.

INTERVIEWER: In your opinion, what is the best place for people to look for information on STI's and AIDS?

JASMIN: I think people should look in the public health system. Then, television, medical opinions on television which are broadcasted by certain shows or public shows on TV... I don't think we lack information, though, this is not why we are getting infected with HIV, because today[**], laboratories for blood tests give you information, schools give you flyers, health clinics, too.

INTERVIEWER: The medical staff?

JASMIN: Yes, the doctor or nurse [**] who could tell people how to get infected or not.

*** Distributing syringes could be understood as an incentive to the use of IV drugs**

JASMIN: Look, the government is very responsible, but not [*]. The Government is responsible because it [**] of the people, paying taxes in every product you buy [*] we pay so many taxes, cars, houses. So, the Municipal, State and Federal Government has the duty of creating units of protection and treatment, and of informing the population about what should be done and how. (...) It is not right to distribute seringes for the people, this is wrong! I am against it. If you do it, you are incentivizing people to get drugged.

***Distribution of condoms could be an incentive to early, unlimited, sex**

JASMIN: They should not give away condoms to celebrate AIDS Day. They should explain to people that they shouldn't be changing partners so much. This story about "you can have as much sex as you want with as many people as you can as long as you use condom" is wrong.

*** Importance of early childhood education**

JASMIN (...). Children who [*] today, has no school, leisure, and health is going to become an adult submerged on drugs, addictions and crimes. She had no childhood!

***Campaigns of high impact are necessary. It is important to show the illness and the problems it does to the human body.**

JASMIN: There are some large and funny campaigns of dressing the obelisk [Obelisk of Seven Square in Belo Horizonte] with large condoms, with balloons all around. Of course they mean "you can have sex as much as you want, just wear condom". But these funny initiatives forget about something: they are not with the person day after day to remind them to put condom when they are about to have sex. So I think that instead of dressing the obelisk with a condom and distribute condoms to the population, they should do the opposite. They should say "this man got AIDS because he did not wear condom [**] of him [**]".

JASMIN: Shock Therapy! They have to use shock therapy because we just learn with hardcore, in the [*]. Because then, people will pass by the obelisk and see a person in the final stage of the disease. [**]. But no, they prefer to put an obelisk with a large condom and lots of balloons around...

*** Incentive to fidelity could be a good strategy**

JASMIN: Yes. You have to educate people. Everything is about education. You asked me if the man is naturally unfaithful, right? I am aware of people who are not unfaithful. I think people should learn thatlook, I am going to tell you something here, even thought you are recording. I don't understand much about changing partners, changing sex, [**] everyone has the right to try one, two, three, four, ten, thirty times, but in the end of this thirty time, there person gets to a point that she will feel tired.

INTERVIEWER: Tired of this search?

JASMIN: Yes. Searching is tiring. And the more one changes partner the more she finds defects and problems in the other person. And even if you change, you will find a person who does not have this defect, but may have others that you did not know about just yet. And then you have another person to write in your list...

INTERVIEWER: List of search?

JASMIN: Yes. And when this list reaches 20, 30, I don't know, you will be alone. Because you will be tired, and you will have come to the terrible conclusion that human beings have defects [**]. So what the person got to understand is that she has to adapt herself to the qualities of the other the person and has to look for the help of each other to transform whatever is a defect in a nice quality. And then, we will finally stop the search and changes of partners.

*** In favor of the distribution of condoms**

INTERVIEWER: What else? What else could be done?

DÁLIA: I believe they should distribute condoms to girls. Because many times the excuse the man use...well, I have many guy friends, from all ages, and what they do is that they take the girl to a motel, and when they are about to have sex, they say they have got no condom. If the girl is excited and wants to be with the man so much she surrenders, poor her, because it is all about feelings. But he is the guilty one.(**).

C – About vulnerability

*** Disinformation on HIV/AIDS is huge**

ROSA: Yes, yes, with the time it changed...It changed because of the disease, right, the HIV who is ruling out there. And there are others, right, such as adeno (?) denides, right? [tonsils] which is ruling too...no no, not ruling, some people got it...adeno...

INTERVIEWER: Adenoide? [Tonsils' inflammation].

*** Doctors do not inform too much because they are always in a hurry**

INTERVIEWER: Have you asked this to your doctor before?

AÇUCENA: yes.

INTERVIEWER: And what did he say?

AÇUCENA: The answer was incomplete.

INTERVIEWER: You did not understand what he said...

AÇUCENA: No.

INTERVIEWER: Didn't you make the question again?

AÇUCENA: No.

INTERVIEWER: Why?

AÇUCENA: Because doctors do not have time, everything is in a hurry.

*** Women are more vulnerable**

INTERVIEWER: Who do you think need more information?

DÁLIA: Women.

INTERVIEWER: Why women?

DÁLIA: Because she will be the discharge, right, the flush, how my mother explains, (**) when you flush the toilet in the bathroom, right? We are the toilet, the receptor of bacteria (...).

*** Elderly are more vulnerable**

JASMIN: Who needs information the most? We all do. But I think the very young and the elderly, because the adults and young adults are very well informed. But the elderly, lets go back in the past, we were raised having sex with animals in farms, with everybody, there was no AIDS [**], so, the acceptance of a 50 year old person regarding condom with a partner is smaller. He doesn't know that he can't be having intercourses with anyone anytime, or oral or anal sex without protection.

D – About facing AIDS

*** Prevention is efficient. People make mistakes because they want to.**

INTERVIEWER: So do you think people get AIDS because they were unfaithful somehow?

VIOLETA: Not unfaithful...People get it, like I told you, not because she did not take care. Everything is very clear nowadays. Everybody talks about AIDS, normally; Government gives things for free...so people make mistakes because they want.

*** Person would have sex if they loved another person with HIV/AIDS.**

INTERVIEWER: Would you have sex with a person if you knew she has HIV/AIDS?

ROSA: If I liked, if I really loved, adored, I would.

INTERVIEWER: Would you?

ROSA: I would.

*** Person would not have sex if they knew the sexual partner has HIV/AIDS**

INTERVIEWER: Do you think people with AIDS can have sex?

MAGNÓLIA: Well, they have to prevent the spread, but they can. But if I knew that someone has AIDS, I wouldn't have sex at all. I don't have the courage, even with 10 condoms on, I wouldn't.

*** The way of infection makes a difference on the decision of ending the relationship or breaking up in case the partners become infected with HIV. Betrayals wouldn't be forgiven, accidental infections would.**

INTERVIEWER: So, let's imagine a man that you like very much, maybe your current partner. One day he comes to you and tells you he has AIDS. How would you react if your husband tells you "I have AIDS!"?

ROSA: I would be terrified. I would ask how he got infected [**]. If he cheated on me, I would leave him right away, I wouldn't have a relationship with him anymore.

INTERVIEWER: You wouldn't have a relationship with him anymore?

ROSA: I wouldn't...

INTERVIEWER: Would you abandon him?

ROSA: I would.

INTERVIEWER: And the form of infection, would it make a difference for you?

ROSA: It would.

INTERVIEWER: For example, if he had got infected in the hospital or cheating on you, would it make any difference?

ROSA: If he had cheated on me, it would make a difference.

3.3 – Services and Public Policies

3.3.1 - SUS and the Ministry of Health

The Constitution of 1988 implemented the SUS [Sistema Único de Saúde, the Brazilian Universal Healthcare System], which is based on a set of principles. Universality is the first. This means that everyone has free access to health services. The SUS must be integral, that is, it must offer every modality needed from health promotion to treatments.

The Ministry of Health has given attention to lesbians, bisexuals, travesties and transsexuals (GLBT) since the beginning of the epidemics of HIV. Now, the feminization and

heterosexualization of the disease have forced the creation of a plan of intervention especially made for women, recognizing that gender and sexual orientation are factors of vulnerability.

According to the National Program of STI/AIDS, the factors that contribute the most for the major vulnerability of women are gender inequalities, such as reduced power of negotiation regarding decisions that involve their sexual and reproductive life; domestic and sexual violence against women and girls; the related discrimination and the prejudice of race, ethnic and sexual orientation. Less access to the services of reproductive health and difficulty in negotiating the use of condoms with partners explains the growing numbers of women contracting AIDS among women (Araújo et al, 2007).

The Integrated Plan of Confrontation of the Feminization of the Epidemic of AIDS and other STIs, created in 2007 by the Ministry of Health, aims at reducing the multiple vulnerabilities that make Brazilian women more susceptible to the infection of HIV and other sexually transmissible illnesses. It suggests public politics to promote prevention, precocious diagnosis and treatment. The main challenge is to deal with socio-cultural aspects of gender inequalities, such as access to available methods of prevention, financial independence and housing.

Other important point is regarding the discouragement of feminine sexuality. It is socially desirable for men that they initiate the sexual life earlier, have many partners, and are always in control of the sexuality of the couple, including negotiating the use of condoms or other contraceptive methods. Thus, according to the Plan, it is very necessary to include men in communication strategies (Brasil 2007, p. 14).

The plan also brings strategies to reduce the vulnerability related to poor education; violence (either physical, psychological, sexual or of another order) which keeps the women vulnerable to their men and to the illness; to ethnics/race, since Blacks and Indigenous are also more vulnerable to violence than Whites, plus Blacks possess vulnerability-associated characteristics, such as poverty, low income, and education level. Therefore,

Poverty and AIDS are correlated: the epidemics of AIDS aggravate the precarious conditions of some population, reproducing the number of poor families, because relative costs to care for an ill member reflects in the familiar income” (BRAZIL 2007, P. 17);

Finally, the plan proposes strategies for dealing with the stigma and disobedience to the Human Rights. The Brazilian newspaper Folha de São Paulo, on August 8th, 2008,

brought one of many examples of disrespect to Human Rights: people who were HIV positive were being expelled from a slum quarter in Rio de Janeiro.

3.3.2 – Municipal Secretary of Health

City Government of Belo Horizonte (BH) / Department of Health

Prevention:

The Program "BH holds hands against AIDS" started in 2001. Winner of prizes and an example to follow, the program aimed toward the improvement of the access to condoms, testing and the reduction of the vulnerability to the infection. Thus, the politics of confrontation of the epidemic started to discuss gender, sexuality, self-esteem, prejudices, race and ethnics. To reach these objectives, the City invested in the training of health professionals and the qualification of information-multipliers, people from the community who attend the courses, and develop educative activities. The multipliers are people born and raised in the community who live the same experiences of the population for which they work. During the training, they have to write a project of prevention to put in action with the local community once they finish the training.

Testing is free for everyone and all local clinics in Belo Horizonte offer it. The decentralization of the testing helped to bring the reality of testing and getting treatment closer to the people.

For pregnant women or candidates for blood donation, the testing is automatic. For those remaining, either the person, or the doctor, has to request it. This is the problem with the elderly: neither the person, nor the doctor, see it as a necessity.

The City also has programs for the interruption of the vertical transmission (pregnant women who are HIV positive not necessarily pass the virus to their child – thus babies may begin taking preventative medications as soon as they are born); and for Intravenous Drugs Users (distributing free syringes – a project of reducing damage which is very critiqued).

Health Managers coordinate the production of materials such as posters, folders, videos and flyers, according to the epidemiologic demands, based on the reports epidemiologists produce for the Municipal Secretary of Health. The City also makes use of the campaigns produced by the Federal Government, besides producing their own. A good example is that Belo Horizonte foresaw the growth of the epidemic among elderly and they

created their first local campaign even before the Federal government. While in Brazil 2% of the infected are aged 60 or more, in Belo Horizonte, this number is 3%.

Care:

The assistance to people who are HIV positive at the municipal level takes place in any public clinic, besides the units with specialized assistance. All the anti-virus medicines are free of charge.

Victims of sexual violence and abuse have a qualified team of professionals to guide them and carry through necessary examinations to supply the medication to treat sexually transmitted diseases and unwanted pregnancy.

Aware that the cases of HIV have been increasing among women with a stable partner, the City offers tips to convince the stable partner to use condoms, appealing to the idea of true love: if you love me, you will help to protect me. Unfortunately, this material is only available online.

**3.3.3 – Secretary of Health of Minas Gerais
Government of the State of Minas Gerais**

The State Secretary of Health distributes medicines gratuitously in the Centers of Testings and Counselling (CTAs), located in major cities in the state. They are responsible for testing for HIV. In case the test comes back positive, the person will receive orientations and specialized treatment.

In 2008, inspired by the Integrated Plan of Confrontation of the Feminizations of the Epidemic of AIDS and other STI, the State Government launched their own Plan of Confrontation of the Epidemic of the AIDS and other STI among women of the State of Minas Gerais. It aims at reducing vulnerability through health promotion, prevention and assistance.

Some of the goals focus on mature women. The State expects to reach its goals in 2011, even though they have not began a number of them. These are:

- Extend the program to 100% of the cities;
- Increase the covering of the diagnosis of the HIV in women;
- Offer counseling and testing to women who are in hospitals to procedures related to miscarriages;

- Promote specific actions of prevention and social inclusion of women who are HIV- positive, elderly, indigenous, works with agriculture, lesbians, handicap or with special needs, Blacks from Quilombos [communities formed by descendents of former slaves], transsexuals and transgender in 100% of the cities;
- Production of specific informative material on prevention of STI/AIDS contemplating the specificities of the groups;
- Offer the fast HIV testing for 100% of the Indigenous who are pregnant and live in the reserves;
- Coordinate the Biennial meeting of the “Positive Citizens”;
- Program four workshops for agricultural workers of the Vale do Jequitinhonha in 2008, including 280 women of Medina, Ponto dos Volantes e Araçuaí;
- Municipal meeting in cities from the inner state;
- Promote access to the prevention in the Penitentiary System;
- Annual meeting of young people who live with HIV;
- Facilitate the donation of feminine condoms to vulnerable population groups.

The State does not produce their own actions of Communication, but reproduces the campaigns received from the Federal Government.

3.3.4 – NGOs in Belo Horizonte

Non-Governmental Organizations listed by the Federal Government and the Municipal Government as a reference dealing with HIV (prevention or treatment)⁷.

We tried telephonic contacts with the Non-Governmental Organizations (NGOs) listed by the Federal Government and Municipal City Hall of Belo Horizonte as reference in HIV/AIDSs, in the city, in a variety of hours and days of the week, but the result was not positive. Few are the NGOs that work specifically toward the prevention of HIV infection in women and/or mature women, and supporting HIV positive women.

Many did not have their contact information up to date, what could make it difficult for a person looking for help. For those telephones were disconnected, no other type of search

⁷ The original work in Portuguese contains a list with the result of every contact done with the NGO's.

was made. Thus, the actual numbers of NGOs, which offer some kind of help, could be underestimated. The Conclusion brings the main results from telephonic contacts.

4 – Descriptions of Campaigns

Throughout more than 20 years of epidemic, Brazil was one of the first countries in the world to disassociate AIDS from death in the communication campaigns. Instead, we privileged the respect to the human rights, the information, the valuation of self-esteem and the incentive to the use of condom.

Besides these differentials in the approach given to the illness, the campaigns against AIDS in Brazil have talked about taboos and caused a long discussion: campaigns about men who have sex with men (2002), adolescent women who do are not ashamed to buy condoms (2003) and even a campaign where a man talks with his penis (1994). Epidemiologists, behavioral research and civil society work together when the Governments think about a campaign.

Some of them have touched the heart of our subject: the mature women⁸.

Campaigns aiming mature women and women in general

Title: Sensuality. Sensibility. Sexuality. In the best age.

Type: Poster, folder and flyer.

Responsible: City Hall of Belo Horizonte.

Text: “The sum of the age of this couple equals 131 years.



⁸ The original work in Portuguese brings a full description of every campaign showed here.

Title: Women, you write your own story (International HIV Day 2004)

Type: Poster, folder, flyers, hat, T-shirt.

Responsible: Federal Government, Ministry of Health.

Text: “Almost half of the people who have AIDS in the world are women. This is not the kind of equality that we want”.



Title: Women against IST and AIDS (Women’s day 2008)

Type: Radio spots

Responsible: Federal Government



Title: Show them you have grown up. This Carnival, use condom (Carnival 2003)

Type: Posters, folders, campaigns for TV, totem, billboards, radio spots.

Responsible: Federal Government, Ministry of Health

Text: “Sex with condom. Or else, you just look and drool”.

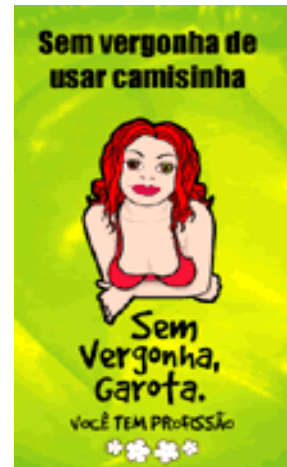


Title: No shame, girl. You have a profession (Campaign 2002)

Type: Folder, flyer, radio spot.

Responsible: Federal Government

Text: “Shameless of using condom”



Other campaigns that indirectly affect women and/or mature women:

Title: Don't take AIDS home (International AIDS Day 2000)

Type: campaigns for TV, radio spots, banners, posters, folders, billboards and an event (movie festival).

Responsible: Federal Government

Title: Condom: the best friend of the road (Campaign 2000)

Type: campaigns for TV, radio spots, banners, posters, folders, stamps for trucks.

Responsible: Federal Government

Title: Be aware (Campaign 2003)

Type: creation of a brand, folder, poster, flyers, T-shirt, stamp, pins, banners, radio spots, hats.

Responsible: Federal Government

Title: Take the weight of the doubt off your shoulders. Get tested. (Campaign 2003)

Type: campaigns for TV, folders.

Responsible: Federal Government



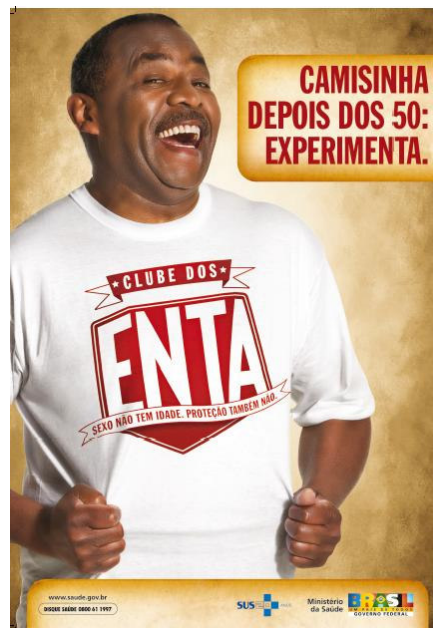
Title: There is no age for sex. Neither for protection. (International AIDS Day 2008)

Type: flyers, folders, billboards, website, campaign for TV and radio spots.

Responsible: Federal Government

Text: “Condom after 50: try it!”

Text in the T-shirt: “Club of the 50’s”



5 - Conclusions

The Federal and Municipal Governments are seriously facing the feminization of the epidemic, and more recently, aging. They have implemented with significant results actions of prevention, such as campaigns, training and distribution of condoms, or actions of assistance, such as more places for testing, and public policies to increase the continuity of the treatment.

NGOs also help in the fight by preparing professional training programs, and caring, so that those who are HIV positive have psychological and economic conditions to continue treatment and not spread the illness (distributing condoms and coordinating help groups).

It is clear that the State Government needs to put into action their Plan of Confrontation in a full manner, so that they also have a marked presence in the fight against the feminization and aging of the infection. By now, all they do is limited to spreading the Federal Campaigns and managing Clinics of Testing and Medicine Distribution (bought with federal money).

Regarding NGOs, these need to improve providing citizens with treatment, keeping their contact information up to date. It is possible that many of them no longer exist due to financial difficulties of maintaining a non-profit organization.

The City Hall of Belo Horizonte, especially through the program “BH holds hand against AIDS” is doing a huge effort to fight the feminization and aging of the epidemics. A proof of this is the elaboration of a campaign focusing on this group earlier than the Federal Government. Our only observation is regarding HIV testing. Talking and offering testing should be mandated in every routine consultation, for people of all the ages, not only pregnant women.

The research also indicated that mature women feel inhibited to talk about sex in the public clinics, what confirms the importance of having trained people to carry out the work in clinics. Moreover, it is necessary that the population knows where the clinics are and which blood tests are free. They should know they can count on the public health system to cure their doubts and problems related to Sexually Transmitted Infections. These suggestions do not imply in greater costs for the health system, since its budget is limited. Nevertheless, they imply the use of communication strategies (mass communication and personal communication) to inform and bring people to clinics.

This research also confirmed that behaviors and attitudes are responsible for vulnerability, despite the level of information about AIDS. Social, cultural and economic

values, amongst which are the religious life, the social context, the family values, and the level of education influence vulnerability. The availability of information on HIV, for example, does not assure the capacity to negotiate the use of condom with the partner.

Nevertheless, we discovered that there are still women today who do not know about HIV, and that the great majority did not use condoms with their last sexual partner (either because the participant was married, in a stable relationship or had already passed menopause). In addition, we discovered that the majority of women would succeed in interrupting sexual intercourse in cases where the partner refused to use a condom, but in many cases, women would not even try to stop it. The majority of women also agree that condoms provide protection from AIDS, but knowledge does not imply the usage.

The conversation about AIDS should exist in the domestic scope, since a large part of the infected women, were infected by their stable partner. According to our sample, most of them had only one sexual partner in the last 12 months.

Thus, campaigns elucidating the most common form of infection (that is, infection from stable partners between heterosexuals) is important, so that women may become aware of this real possibility. A campaign for couples could also stimulate the dialogue between the sexual partners, so that AIDS and extramarital relationships stop being taboos and become a possibility for both sides. Therefore, if it is not possible to use condoms because they really think that marriage does not combine with condoms, it is possible that the partners create strategies to protect themselves in case they have extramarital sex, and create the habit of testing periodically. It is important, however, to give conditions to the woman to negotiate the use of the condom, empowering her so that she can request a condom in case she suspects of infidelity from her partner, or in any other occasion that she desires to have protection.

To encourage fidelity can also be a good strategy, according to mature women. Instead of valuing the sexist behavior, that man must have multiple partners, or that women must be in the perpetual search from the perfect man, it is interesting to think about the partner as a life friend, with qualities and defects, since nobody is perfect.

According to the qualitative interviews, mature women lack information about the procedures of using masculine and feminine condoms. For a pre-AIDS generation, wearing a condom could be complicated, and the feminine condom, if cheaper, could be of a great help for partners with erectile dysfunction, because the feminine condom addresses men's fear of losing an erection while trying to put on a condom.

Women cited as sources of information the traditional public clinics, didactic courses, television, library, campaign materials, family and friends. They suggest as good sources laboratories and popular newspapers. They want to see more information about how to put the condom on, and about other infections. They also have cited the responsibility of the popular media (radio and TV) in the prevention, and they even thought about soap operas, which possess language and specific mechanisms capable to reach many publics, specially mature women (big part of the audience of soap operas is made of mature and elderly women).

For mature women, the funny, good humor of light campaigns does not work. They all prefer serious campaigns or high impact, showing the problems that the illness can cause in the human body. This goes against the need for humanization of the ill, since a high impact campaign could cause stigma and more prejudice, two ideas that took years of debate to be withdrawn from the campaigns. Since women request condom when the penis or the vagina are unclean, perhaps it is interesting to talk about the opportunistic illnesses, or the problems that other STI can cause in a woman's body, as infertility, itchiness and wounds. Then they would feel the fear they need to start using condom.

The research also confirmed old information, such as difficulties in the access to contraceptives (condoms are expensive, a pack of three cost as much as a liter of milk), and the refusal to put the condom "not to cut up the arousal". It is necessary, therefore, to distribute condom closer to their houses, or to sell it cheaper by means of tax incentives. I believe that explaining the physiological structure of the female body (many women and men do not know their physiology), calling attention to the fact that the female reproductive tract is highly susceptible to infections and open to the abdominal cavity can cause fear of infections, leading to a better use of the condom.

In spite of the level of indifference with regard to the use of the condom, it is easy to perceive that a certain fear exists and much prejudice with regard to the sick person, as if the death was a next destination and the life had finished. It is extremely important to make campaigns to demystify this fact and talk about the quality of life after-HIV with anti-viral treatment. Finally, it is interesting to notice that the great majority of the interviewees say that she would not have sex if she knew that the other person has the virus. This inspires us to suggest a campaign that identifies every person as a HIV positive. Thus, we could think of something like "we are all HIV-positives. Always use a condom".

Finally, Communication is a science that can act in the prevention and treatment of HIV/AIDS by means of dialogue, dissemination of correct and up to date information, and by acting in the cultural and symbolic questions that surround the relations of human beings. However, we indicated three great challenges in the vulnerability and gender fields, which make difficult the elaboration of some of the suggestions above. The first great challenge is that campaigns seem to be insufficient to diminish the gender inequalities of women. Second, even if we diminish the wage gap between men and women, this does not guarantee equality of negotiation between them. Brazil has many programs of money transference that can prove so. Third, using high impact images can make it difficult the identification of the public with the “abnormal being” showed on TV, leading to a feeling of invulnerability. On the other hand, campaigns which presents AIDS as a daily routine, could cause an ordinarization of the illness and lead to the apparent unnecessary protection (as a woman said, AIDS is like a cancer, some people have it, some don’t). Thus, an addition of efforts from the most diverse areas of science has to come together, so we can successfully intervene in the vulnerability of mature women.

We hope this project clarified the participation of Communication in guiding the construction of democracy and human rights, and of Demography, lending techniques and subsidies of analyzes for these constructions.

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Attachments

Table 1: Socio-demographic characteristics / Women, White and Black, 50 to 59 years old, Belo Horizonte, MG, Brazil, 2002 (continue)

	Category of answer	Race/color (%)		Total
		White	Black	
Years of Education	1 to 3	11,11	24,00	17,31
	4 to 7	20,99	41,33	30,77
	8 to 10	11,11	6,67	8,97
	11 +	56,79	28,00	42,95
N = 156				
Total		100	100	100
Number of bathrooms in the household	0	0,00	0,00	0,00
	1	31,46	59,76	45,03
	2	35,96	28,05	32,16
	3	26,97	6,10	16,96
	4	3,37	2,44	2,92
	5	0,00	2,44	1,17
	6	2,25	1,22	1,75
N = 171				
Total		100	100	100
Material of the ceiling	titles	43,68	36,59	40,24
	concrete	56,32	63,41	59,76
	zinc	0,00	0,00	0,00
N = 169				
Total		100	100	100
Civil Status	married	60,92	50,00	55,62
	living together	3,45	2,44	2,96
	single	12,64	19,51	15,98
	divorced/separated	13,79	10,98	12,43
	widow	9,20	17,07	13,02
N = 169				
Total		100	100	100
If worked or did any activity in the previous week (paid and unpaid)	no	12,64	23,17	17,75
	yes	87,36	76,83	82,25
N = 169				
Total		100	100	100

Health Insurance	no	34,48	53,09	43,45
	yes	65,52	46,91	56,55
N = 168 Total		100	100	100
Religion	None	10,23	2,44	6,47
	Catholic	63,64	60,98	62,35
	Protestant	4,55	6,10	5,29
	Pentecostal	7,95	23,17	15,29
	Spiritist - Kardecista	10,23	7,32	8,82
	Other	3,41	0,00	1,76
N = 170 Total		100	100	100
Type of household	Own, paid	80,46	74,39	77,51
	Own, paying	2,30	8,54	5,33
	Rented	10,34	10,98	10,65
	Donated	4,60	4,88	4,73
	Other	2,30	1,22	1,78
N = 169 Total		100	100	100
Household wage (in min. wage - 2002 = R\$200,00)	None	0	0	0
	up to one	1,1	6,1	3,6
	from one to two	9,2	15,9	12,4
	from two to three	5,7	7,3	6,5
	from three to four	10,3	9,8	10,1
	four or more	63,2	41,5	52,7
	NA or does not apply	10,3	19,5	14,8
N = 169 Total		100	100	100
Women's wage* (in min. Wage - 2002 = R\$200,00) *excluding housewife, retired and unemployed.	None	2,2	1,2	1,8
	up to one	4,5	6,2	5,3
	from one to two	10,1	16,0	12,9
	from two to three	10,1	4,9	7,6
	from three to four	10,1	2,5	6,5
	four or more	13,5	6,2	10
	Doesn't work or NA	49,4	62,9	55,9
N = 170 Total		100	100	100

Parity	Medium number of child per woman	3,16	3,52	3,33
		87,45	81,68	169,13

Source: SRSR, Cedeplar/UFGM, 2002.

Table 2: Sexual and Reproductive Health of Black and White women, 50 to 59, Belo Horizonte, MG, Brazil, 2002.

	Category of answer	Race/color (%)		Total
		White	Black	
Do you or your partner use any contraceptive method?	No	39,77	30,49	35,29
	Yes	55,68	57,32	56,47
	Pregnant or missing	4,55	12,20	8,24
N = 170				
Total		100	100	100
Which method do you use?	Pills	2,27	0,00	1,18
	IUD	1,14	0,00	0,59
	Male condom	3,41	2,44	2,94
	Female sterilization	45,45	53,66	49,41
	Abstinence	2,27	1,22	1,76
	Withdraw	1,14	0,00	0,59
	None	44,32	42,68	43,53
	N = 170			
Total		100	100	100
What is the main reason for you not to be using any method?	Not in an relationship	5,75	1,23	3,57
	Does not have sexual intercourse	4,60	8,64	6,55
	Sex not frequent	1,15	0,00	0,60
	Menopause	19,54	12,35	16,07
	Histerectomized	5,75	3,70	4,76
	Steril (difficulty conceiving)	1,15	1,23	1,19

	Wish to have more children	1,15	0,00	0,60
	Fear of side effects	1,15	0,00	0,60
	Interfere with body functions	0,00	1,23	0,60
	Using method or NA	59,77	70,37	64,88
	Doesn't know	0,00	1,23	0,60
N = 168				
Total		100	100	100
	No	23,86	31,71	27,65
	Yes, not related to pregnancy	75,00	65,85	70,59
	Pregnant related	1,14	1,22	1,18
	Doesn't know, doesn't answered	0,00	1,22	0,59
N = 170				
Total		100	100	100
	No	12,64	14,81	13,69
	Sim	87,36	83,95	85,71
	Doesn't know, doesn't answered	0,00	1,23	0,60
N = 168				
Total		100	100	100
	Nobody	27,27	34,57	30,77
	regular	2,27	2,47	2,37
	ocasional	1,14	2,47	1,78
	married or united	68,18	60,49	64,50
	Doesn't know, doesn't answered	1,14	0,00	0,59
N = 169				
Total		100	100	100
	Never married	8,05	12,20	10,06
	married or united	59,77	46,34	53,25
	United	9,20	13,41	11,24
	Separated/Divorced	13,79	13,41	13,61
	Widow	9,20	14,63	11,83

N = 169

Total	100	100	100	
	0	33,71	45,68	39,41
	1	1,12	2,47	1,76
	2	10,11	9,88	10,00
	3	15,73	3,70	10,00
	4	8,99	17,28	12,94
	5	2,25	2,47	2,35
	6	2,25	0,00	1,18
	7	2,25	0,00	1,18
	8	3,37	8,64	5,88
How many times do you have sexual intercourse per month?	9	1,12	0,00	0,59
	10	5,62	0,00	2,94
	12	2,25	2,47	2,35
	15	1,12	2,47	1,76
	20	2,25	1,23	1,76
	25	2,25	0,00	1,18
	30	0,00	0,00	0,00
	NA	3,37	1,23	2,35
	Doesn't know, doesn't answered	2,25	2,47	2,35

N = 170

Total	100	100	100	
Did you use condom with your last partner?	No	59,09	51,22	55,29
	Yes	7,95	6,10	7,06
	NA	32,95	42,68	37,65

N = 170

Total	100	100	100	
Do you think your risk of getting infected with HIV is big, moderate, small or there is no risk at all?	No risk at all	50,00	69,51	59,41
	Small	27,27	17,07	22,35
	Moderate	15,91	10,98	13,53
	Big	4,55	1,22	2,94
	Doesn't know, doesn't answered	2,27	1,22	1,76

N = 170

Total	100	100	100	
If your most recent partner did not want to use condom, but you wanted, do you think you could avoid the intercourse?	Certainly	64,77	65,85	65,29
	With some certain	9,09	7,32	8,24
	Wouldn't try to avoid	22,73	23,17	22,94
	NA	3,41	1,22	2,35

	Doesn't know, doesn't answered	0,00	2,44	1,18
N = 170				
Total		100	100	100

Source: SRSR, Cedeplar/UFGM, 2002.

Table 3: Vulnerability to HIV, women, white and black, 50 to 59 years old, Belo Horizonte, MG, Brazil, 2002.

	Category of answer	Race/color (%)		Total
		White	Black	
have you heard of sexually transmitted infections?	No	6,82	3,70	5,33
	Yes	93,18	96,30	94,67
N = 169				
Total		100	100	100
If she cited Aids as STI, expontaneously.	No	29,55	28,40	28,99
	Yes	63,64	67,90	65,68
	NA	6,82	3,70	5,33
N = 169				
Total		100	100	100
Have heard of Aids (when asked)	Yes	35,63	32,93	34,32
	NA	64,37	67,07	65,68
N = 169				
Total		100	100	100
There is a cure for Aids	No	81,61	86,59	84,02
	Yes	5,75	6,10	5,92
	Doesn't know, doesn't answered	12,64	7,32	10,06
N = 169				
Total		100	100	100
Aids can be controlled	No	4,60	3,70	4,17
	Yes	89,66	87,65	88,69
	Doesn't know, doesn't answered	5,75	8,64	7,14
N = 168				
Total		100	100	100

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	No, doesn't pay	10,23	8,54	9,41
Do you know if the government pays for the treatment	Yes, it pays	61,36	56,10	58,82
	Doesn't know, doesn't answered	28,41	35,37	31,76
	N = 170 Total	100	100	100
	Never done	73,86	84,15	78,82
Have you ever got tested for HIV? More or less than a year ago?	Yes, less than a year ago	7,95	6,10	7,06
	Yes, more than a year ago	17,05	9,76	13,53
	Doesn't know, doesn't answered	1,14	0,00	0,59
	N = 170 Total	100	100	100
	0	76,14	81,71	78,82
Number of symptoms of STI that she is experiencing right now	1	14,77	4,88	10,00
	2	3,41	9,76	6,47
	3	0,00	1,22	0,59
	4	0,00	1,22	0,59
	NA	3,41	1,22	2,35
	Doesn't know, doesn't answered	2,27	0,00	1,18
	N = 170 Total	100	100	100

Source: SRSR, Cedeplar/UFMG, 2002.