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HIV prevention under the view of indigenous women from the Potiguara tribe*

Prevenção do HIV sob o olhar de mulheres indígenas potiguaras*

Prevención del VIH según la perspectiva de mujeres de la tribu indígena potiguara*

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Abstract: Objective: to analyze the way in which the prevention of infection by the human immunodeficiency virus (HIV) is configured under the view of women from the Potiguara ethnic group. **Method:** a qualitative study involving 256 women from three indigenous villages in Paraíba-Brazil The information was collected in 2015, through the Free Word Association Test and semi-structured interviews. The *corpus* was analyzed from the Descending Hierarchical Classification, Content Analysis, and Similitude Analysis. **Results:** three classes of content related to HIV prevention were identified: "Vulnerability to HIV infection"; "Protective measures"; and "Need for health education". The word "condom" occupied the central position in the similarity analysis. **Conclusion**: although they recognize the means for preventing HIV, it is difficult to perform protected sexual practices. Such condition is crossed by social and gender inequalities, which extend to the reality of non-indigenous women.

Descriptors: Health of indigenous populations; Acquired immunodeficiency syndrome; HIV; Women's health; Prevention of diseases

Resumo: Objetivo: analisar o modo como a prevenção da infecção pelo vírus da imunodeficiência humana (HIV) se configura sob o olhar de mulheres da etnia potiguara. **Método:** estudo qualitativo, que envolveu 256 mulheres,

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procedentes de três aldeias indígenas da Paraíba-Brasil. As informações foram coletadas em 2015, por meio do Teste de Associação Livre de Palavras e entrevista semiestruturada. O *corpus* foi analisado a partir da Classificação Hierárquica Descendente, Análise de Conteúdo e Análise de Similitude. **Resultados:** foram identificadas três classes de conteúdos relacionados à prevenção do HIV: "Vulnerabilidade à infecção pelo HIV"; "Medidas protetivas"; e "Necessidade de educação em saúde". A palavra "preservativo" ocupou a posição central na análise de similitude. **Conclusão**: embora reconheçam os meios de prevenção do HIV, há dificuldade para exercitar práticas sexuais protegidas. Tal condição é atravessada pelas desigualdades social e de gênero, extensivas à realidade das mulheres não indígenas.
Descritores: Saúde de populações indígenas; Síndrome de imunodeficiência adquirida; HIV; Saúde da mulher; Prevenção de doenças

Resumen: **Objetivo**: analizar de qué manera se configura la prevención de la infección por el virus de la inmunodeficiencia humana (VIH) según la opinión de mujeres de la etnia potiguara. **Método:** estudio cualitativo en el que participaron 256 mujeres, procedentes de tres aldeas indígenas de Paraíba-Brasil. Los datos se recolectaron en el año 2015, por medio del Test de Libre Asociación de Palabras y de entrevistas semiestructuradas. El *corpus* se analizó a partir de la Clasificación Jerárquica Descendente, del Análisis de Contenido y del Análisis de Similitud. **Resultados:** se identificaron tres clases de contenidos relacionados con la prevención del VIH: "Vulnerabilidad ante la infección por VIH"; "Medidas de protección"; y "Necesidad de educación en salud". La palabra "preservativo" ocupó la posición central en el análisis de similitud. **Conclusión**: aunque reconocen los medios para prevenir el VIH, las mujeres tienen dificultades para llevar adelante prácticas sexuales protegidas. Dicha condición se ve atravesada por desigualdades sociales y de género, extensivas a la realidad de las mujeres no indígenas.
Descriptores: Salud de poblaciones indígenas; Síndrome de inmunodeficiencia adquirida; VIH; Salud de la mujer; Prevención de enfermedades

Introduction

In the last decades, the changes that occurred in the course of the epidemic caused by the human immunodeficiency virus (HIV) have given it different configurations. If HIV infection initially constituted essentially an individual problem, approached from a biomedical and behavioral perspective, the growing attention given to its socio-cultural dimensions led to a broader understanding of the diverse and complex factors related to the dynamics of the epidemic. Living with the infection highlighted the inability of society to deal with social inequalities, gender dissymmetry, power imbalances, ethnic and cultural differences.[1] This situation, in line with the Sustainable Development Goals (SDGs), boosted global guidelines, calling for greater focus on population groups disproportionately affected by the epidemic, recommending integrated and culturally competent preventive approaches.[1-2]

Globally, the involvement of young women, adolescents, and groups with little or no social protection stands out. Of the total of 36.9 million people living with the virus in the world, 18.8 million are women.[2-3] Although a 25% reduction in new infections has been observed in the last decade among young women aged 15 to 24 years old, the weekly occurrence of 6,000 new infections in this group remains unacceptable.[1]

In Brazil, between 2007 and June 2019, 300,496 new HIV infections were reported, 207,207 (69%) of which were men and 93,220 (31%) were women. The highest concentration of cases was observed in individuals aged between 20 and 39 years old, in both genders, corresponding to 68.6% in males and to 57.4% in females. Among women, the most prevalent category of transmission (86.5%) was sexual.[4] In Paraíba, 5,451 HIV cases were reported in the same period, and the male to female ratio was 2.4.[5]

As a complementary tool to face this epidemic, the "Combined Prevention" strategy was instituted, which makes simultaneous use of different prevention approaches, covering biomedical, behavioral, and socio-structural ones, aiming to respond to the specific needs of certain audiences.[6] The combination of these actions expands the possibilities of the individuals to protect themselves against the virus, offering alternatives of greater reach to vulnerable populations. Among others, it provides actions aimed at the socio-cultural conditions that directly influence the vulnerability of specific individuals or groups to HIV, involving prejudice, stigma, discrimination or any other form of alienation of fundamental rights and guarantees to human dignity.

Recognizing the existence of multiple points of intersection among the underlying causes of HIV infection, the challenge is to induce preventive approaches, which take into account the socio-cultural aspects that surround the female universe. Historical-cultural determinations, moral values, difficulty in negotiating safe sexual practices, restricted access to health services,

and protective measures distinguish gender inequalities and the growing violence against women.[7]

In turn, in the case of the indigenous population, HIV prevention actions require a careful look and treatment so that cultural specificities are respected. They must incorporate indigenous representations about health, illness, and healing strategies in their programming, adapting them to their health practices in order to make them culturally appropriate for each ethnic group.[8] In Brazil, it is estimated that there are 896 thousand indigenous individuals, of 305 different ethnicities, with 274 languages being identified, which reveals great socio-cultural diversity.[9] Some ethnic groups remain untouched, without society co-living. However, several tribes suffered intercultural influence due to the approach to urban centers, which collaborated for the spread of diseases and HIV infection.[10]

The profile of the epidemic in this group is little known. According to records of the Notification System for Notifiable Diseases, the percentage of HIV cases in indigenous people during the period from 2007 to June 2019 corresponded to 0.4% of the cases found in the general population. However, data show that the infection has been concentrated among indigenous people living in urban areas and among young women.[10] In this context, female vulnerability is often peculiar to cultural values, experiencing traditions such as patriarchy, *machismo*, and religious rituals that enhance the risk situations to which they are exposed.[11]

In this perspective, which places the condition of women as a center for debate and reflection, it is worth noting how complex and diverse the demands of this population are. The most urgent challenge is characterized by the adaptation of health policies and practices, in order to make them culturally appropriate to each ethnic group, as well as the understanding of their specificities within the cultural otherness that differentiates them.

Therefore, in the field of indigenous health, it becomes pertinent to discuss aspects related to HIV prevention in order to structure and implement truly competent actions in the

management of the infection. In this way, it is intended to give visibility to the expression of this problem in the Potiguara people, given the scarcity of productions with this perspective. Given these initial notes, this study has the following research questions: What do indigenous women think about HIV prevention? Is HIV prevention influenced by ethnic peculiarities?

Consequently, this discussion becomes relevant to the field of nursing, especially to know the particularities that guide the ways of preventing this infection, clarifying the need to use indigenous cultural codes for a better effectiveness of these actions. Therefore, this study aimed to analyze the way in which HIV prevention is configured under the view of women from the Potiguara ethnic group.

Method

A descriptive study of a qualitative nature, involving 256 Indians from the three villages belonging to the area adjacent to the municipality of Rio Tinto Paraíba: Mont-Mór, Jaraguá, and Silva de Belém villages. The first two are more populous and closer to the urban region, and the third is located in a rural area, with greater economic vulnerability. These villages are part of the Potiguara Special Indigenous Sanitary District (*Distrito Sanitário Especial Indígena Potiguara*, DSEI-28), which represents one of the 34 DSEIs distributed throughout Brazil. It is a decentralized management unit of the Indigenous Health Care Subsystem, integrated with the Unified Health System (*Sistema Único de Saúde*, SUS), whose service organization model is oriented towards a well-defined dynamic, geographical, population, and administrative ethnocultural space. In each village/community there is an active Indigenous Health Agent (*Agente Indígena de Saúde*, AIS), whose activities are linked to a health center. It is worth noting that the Potiguara people communicate in Portuguese, despite preserving communication in the Tupi language.

The sample calculation was based on the totality of women aged between 18 and 65 years old living in the villages (N=739), which admitted a 5% significance level, under the 95% confidence level and an anticipated value of proportion (p) equal to 0.50. Proportional sharing was chosen as the sampling criterion, considering the female population in each village: 158 women in the Mont-Mór village, 64 in Jaraguá, and 34 in Silva de Belém. The participants were selected by non-probabilistic sampling, for convenience, adopting the following inclusion criteria: being a woman of the Potiguara ethnicity; aged 18 to 65 years old; and residing at the study site. Women affected by health problems, and who had communication difficulties were excluded.

Two techniques were used in order to obtain the empirical material. Initially, the Free Word Association Test (*Teste da Associação Livre de Palavras*, TALP) was used, with the expression "HIV prevention" as an inducing stimulus. This technique is used to obtain data that enable projective information regarding the participants' mental processes.[12] Sequentially, a semi-structured interview script was used, with questions about identification (name of the village, age, and marital status) and questions that addressed information, attitudes, and difficulties related to the preventive aspects of HIV.

The interviews took place between March and September 2015, conducted by a team composed of five elements, including the responsible researcher, being a PhD student in Nursing, two undergraduate students in Physiotherapy, and two nurses who are members of the Center for Studies on HIV and AIDS, Health and Sexuality (*Núcleo de Estudos em HIV e AIDS, Saúde e Sexualidade*, NEHAS) of the Federal University of Paraíba, all properly trained and qualified.

Each participant was asked by an interviewer who introduced himself as a researcher, invited her to participate in the interview, provided information about the nature and objectives of the study, and requested her permission to participate by signing the Free and Informed

Consent Form. The interviews were audio-recorded with a mean duration of 30 minutes and took place in different spaces (homes, health services, schools, and huts), considering the participant's comfort. For this, private settings with a minimum of noise were sought, with the presence of only the interviewer and the participant.

The transcribed results comprised the *corpus,* which was subjected to a refinement to exclude vocabulary repetitions, grouping of words by semantic approximation and composition of a dictionary. Two researchers validated the dictionary. Sequentially, the information was processed by the IRaMuTeQ Textual Analysis software (*Interface de R pour les Analyses Multidimensionnelles de Textes et de Questionnaires*-Version 0.6 alpha 3), which classified the text segments according to their respective vocabularies generating the Descending Hierarchical Classification (DHC).[13] Of the total of 256 Initial Context Units (ICUs) present in the *corpus*, 522 Elementary Context Units (ECUs), were retained, with 74.6% utilization, resulting in classes of responses on HIV prevention, based on vocabulary and by the variables that contributed to the formation of each class, selected according to the chi-square values (X^2).

The interpretative analysis of the *corpus* took place through the use of Content Analysis, thematic modality,[14] which indicated the convergence of empirical characteristics around three themes, *a posteriori* called as follows: Vulnerability to HIV infection; Protective measures; and Need for health education.

Additionally, the textual conjuncture was subjected to the similitude analysis technique, which grouped and graphically organized the words according to their frequency, allowing for quick identification of the competitions and connectivity among the words.[13]

The study respected Resolution No. 466/2012 of the National Health Council and Resolution 304/2000, with regard to the special theme of “indigenous populations”, being approved by the National Council for Research Ethics (*Conselho Nacional de Ética em Pesquisa*, CONEP) on 01/26/2015, under opinion No. 975,370. In order to guarantee the

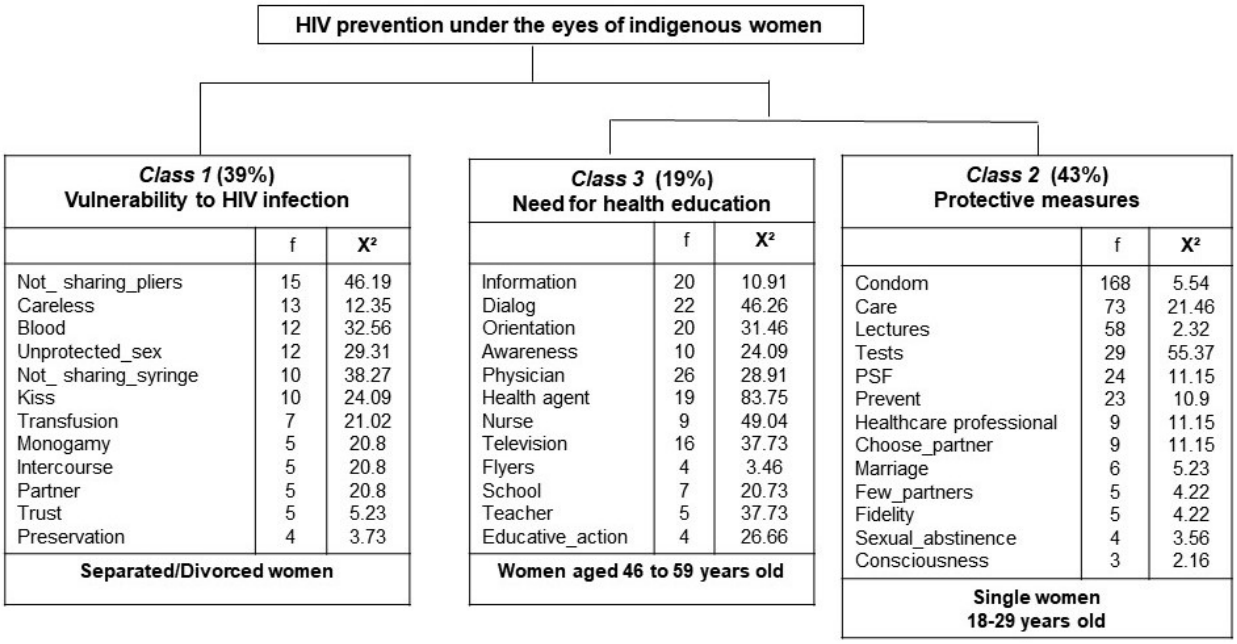
confidentiality of the information and the anonymity of the participants, the statements were coded by the letter "n" plus *underscore* and Arabic numbers corresponding to the increasing chronological order of the interviews.

Results and Discussion

In the surveyed sample (n=256), there was a predominance in the age group of 30-45 years old (38.7%), married/in a stable relationship (73.8%), with up to eight years of study (56.6%), and a family income of 1 to 2 minimum wages (67.2%).

In the analysis of the *corpus*, it is observed from the dendrogram (Figure 1) that the first partition originated 2 subgroups. The first subgroup consisted of class 1, called **Vulnerability to HIV infection**. The second subgroup consisted of classes 2 and 3, designated as **Protective measures** and **Need for health education**, respectively.

Figure 1 – Dendrogram referring to the distribution of the vocabulary of the classes according to the Descending Hierarchical Classification. Rio Tinto – PB, Brazil (2018).



Class 1 – **Vulnerability to HIV infection** - concentrated 39% of the ECUs, being predominantly composed of separated/divorced women. The contents showed that the

weaknesses in the adoption of preventive practices are related to carelessness, lack of preservation, the sharing of personal objects (nail pliers) or even resulting from transfusion and contact with contaminated blood. Sexual intercourse, combined with trust in the partner and monogamy, perpetuates unprotected sexual practices and behaviors.

In this context, conservative conceptions prevail, not unlike the first decades of the epidemic, in which knowledge about HIV infection and the clinical manifestations of the syndrome reinforced the discourse of accountability and blame for the negligent attitudes adopted by people. It is believed that this stigma was due to the ways of transmission of the virus and pre-epidemic social patterns, based on sexual morality and prescription about what would be appropriate sexual behavior.[7] However, it seems that this understanding is still shared today:

They get this disease through carelessness. (n_157)

Not prevented and caught the disease. (n_153)

Should have prevented, listened to advice. (n_068)

An ethnographic study, carried out with indigenous groups living in northern Tocantins and southern Maranhão, showed that the occurrence of sexually transmitted diseases or infections was recognized as a product of individualized practices, with the health-disease-illness process being congruent to interethnic contacts.[15] Contracting HIV through sexual practice seems to depend more on the will and, therefore, implies more guilt. In the text fragments, the construction of the same stigmatizing repertoire identified in other social groups is observed. The experience of living with HIV is seen by many as something shameful, leading those affected by the virus to feel guilty and responsible for not adopting preventive measures and, consequently, causing their own infection.[16]

However, in contemporary times, it is admitted that vulnerability to HIV is expressed in a three-dimensional way. In this way, it goes beyond the individual sphere and extends to the social and programmatic or political-institutional space.[17] From this perspective, it is recognized that the individual, society, and the State are co-responsible for the possibilities of exposing people to the virus as well as the subsequent illness.

In addition to sex, contact with blood from injuries and transfusions was also cited as a means of HIV transmission. However, distorted information still remains, translated into the statement that the infection can be acquired by kissing.

> *The biggest risk is through sexual intercourse, someone else's nail pliers, kiss.* (n_154)

> *They say the disease is transmitted through kisses, blood transfusions, manicures and sexual intercourse.* (n_032)

The representations that indigenous peoples usually make about blood, bodily fluids, the constitution of life, and the spread of diseases still require further investigation and anthropological studies. Some ethnic groups use sharp objects to scarify the skin, remove weak blood, and apply herbs in order to receive strength from spiritual entities. Depending on the tribe, the use of the permanent tattoo is a ritualistic practice belonging to culture and history. In addition to the aesthetic intention, meanings of divine protection and passage to adult life are attributed.[18] However, for other peoples, like the indigenous timbiras, blood is already considered an eminently dangerous substance that transmits diseases.[15]

On the other hand, when citing kissing as a way of transmitting the virus, they reveal the limitations of knowledge about the possibilities of HIV infection, which is still common in non-indigenous populations. The act of kissing, especially on the mouth, was referred as a way of transmitting the virus, although science has shown that saliva is not recognized as a means of HIV transmission.[19-20]

Another relevant point refers to the trust in the partner as a protective factor against HIV infection. This is a problem similar to studies with the non-indigenous population, posing a challenge for HIV control policies, since women's knowledge about the forms of transmission does not guarantee the incorporation of virus prevention actions.

> *The majority gets it (HIV) without knowing, they are victims, they trusted their partner. Nobody cares about it, love, happiness matters.* (n_016)

> *It is transmitted when you have a relationship with someone you don't know.* (n_158)

> *I always ask my husband if he only lives with me, he says yes, that's why I trust him.* (n_146)

The weaknesses of women in dealing with the faces of vulnerability to HIV demand overcoming, arising from empowerment. It is understood that this should be supported by political strategies based on the cultural peculiarities of indigenous and non-indigenous communities.

In this process, it is important to note that the partners' serological *status* is often unknown or inconsistent. In addition, reproductive intentions, care with prevention, reaching preventive elements, and predilection for sexual practices are sometimes mismatched. Thus, a diversified horizon of exposure to HIV is expressed, with a chance of inaccuracies in preventive practices.[21] From this perspective, there is an emerging necessity to recognize the social and programmatic elements of vulnerability, as it understands that conjunctural factors move the individual in his daily life, and that access to care offered by institutions demands commitment and investments in preventive actions. It is understood that these axes interact dynamically and are fundamental to promote sustainable access to integrated care with an emphasis on prevention.

When addressing the trajectories of women living with HIV in Brazil, the importance of considering the contexts of life and female confrontation in care practices was highlighted. It was also highlighted that strategies aimed at a concentrated epidemic can lead to inattention with populations considered non-priority.[22]

Class 2 - **Protective measures** - concentrated 43% of the ECUs, being predominantly represented by single women, aged between 18 and 29 years old. This class presented elements related to the need for care in the face of sex in the villages, which especially require preventive actions with a focus on condom use, choice of partner or even sexual abstinence.

> *We must protect ourselves with condoms.* (n_069)
>
> *The partner does not accept having sex with a condom, so many problems happen.* (n_017)
>
> *Many people think that condoms are uncomfortable, especially men who don't want to use them.* (n_132)
>
> *Man wants his wife without a condom. When the woman says you have to use a condom, the man says I don't want to, but the woman has to take the initiative, because she will get this disease.* (n_020)

Even recognizing the importance of condoms, the low intention of use by their partners accentuates the vulnerability of these women to HIV and other STIs. Rejection or low adherence to condoms, due to the belief about its reducing effect on sexual pleasure, points to a pattern that is not exclusive to indigenous culture. In turn, it indicates limited discussion power for women regarding safe sexual practices, including those living with HIV. Given these circumstances, it is appropriate to state that gender aspects increase female vulnerability and have negative repercussions for the health of women and men.[23-24]

Even though gender stereotypes and living conditions impair female sexual autonomy and increase exposure to HIV, the stigma associated with infection cooperates to hide gender inequalities, which are implicated in women's vulnerability to the virus. Confronting the stigma related to the involvement of women presupposes micro- and macro-structural changes, as well as cultural procedures, with the potential to cease gender stereotypes and expand women's sexual autonomy.[25] Restrictions on the power to participate in the decisions about sexual and reproductive life, in addition to culturally determined emotional coercions, interfere with HIV prevention among women.

Furthermore, it is known that in some indigenous lands extramarital sexual practices are naturally admitted, being related to pleasurable situations of human coexistence. In festive rituals extra-marital relationships may occur, with jealousy being discouraged.[15] However, in the Potiguara context, such behaviors are interpreted by Indian women as disrespect, neglect regarding the use of condoms, and inattention towards the wives.

> *Most men here do not respect women. They have their wives, but there's somebody else on the outside. We don't know about the other, we know about us. If they don't want to use a condom with their wives, use with the other. No one will assume that they cheat. That is why the index is increasing here in the village. I have a friend who has HIV. She got it from her husband.* (n_122)

> *You have to be careful with your husband who may have sex outside marriage. If you are suspicious, you have to use a condom.* (n_065)

> *My husband is 64 years old, he can go out and meet a person with AIDS and bring the disease to me.* (n_105)

Although the report alludes to the husbands' lack of respect and betrayal, the discussion of indigenous polygamy emerges as a current practice, reserved only for men. The transparency and acceptance of this condition by women is rooted in the culture of some ethnic groups. In

the case of the Potiguaras, polygamy is not a determinant of local culture, but their consent by women is associated with situations of financial dependence. The present conviction concerns the hierarchy, subordination, domination, and social position of men in indigenous villages. In many ethnicities, man occupies the position of provider of the family, and there is a tradition regarding the obedience and respect for the husband on the part of his wives, who reproduce this behavior to other generations.[26]

When exploring some of the more general meanings of the notion of sexual negotiation, a conformity of the female figure is often seen in the villages, attributing to herself the responsibility of safeguarding her integrity with careful measures in the choice of partners.

> *You have to be very careful, especially during intercourse with your partner. Know what kind of person you are relating with.* (n_070)

> *Women should take precautions, not have many partners, have a stable relationship.* (n_105)

> *We must choose the partner we are going to have a relationship with.* (n_069)

> *The person has to use a condom, we never know tomorrow, if the partner is correct.* (n_093)

In Brazil, heterosexual relationships are based on patriarchal values, in which a dissymmetry of roles between men and women is evident. Such aspects are associated with sociocultural stereotypes that guide female behavior and shape gender inequalities and violence. This type of violence has been expressed as a critical health problem, which is perpetuated by invisibility and underreporting.[27-28] They resemble the normative pattern of sexual behavior of the hegemonic western model, in which marriage is monogamous, being associated with conjugal fidelity. Despite this, they are attentive to exposure to STIs and to condom use.

Potiguar women reinforce selective and careful conduct, in view of relationships considered stable. In addition, they signal concern for young women, who have sexual relations in other formats of relationships.

> *Here in the village there are many young girls who get involved with several partners, but nobody knows if any of them have AIDS, because HIV tests are missing here. 11-year-old, 12-year-old and 13-year-old girls are vulnerable to becoming infected with AIDS.* (n_071)

For some indigenous tribes, menarche signals that the girl started her sexual life and that she must point out the man with whom she had intercourse so that the dowry is demanded. In addition, single women admit a social stance in which they maintain a free sexual behavior and are respectfully recognized in the village.[15] However, in the Potiguara culture, such practices are not allowed.

In the indigenous scenario on the agenda, there is an acknowledgment of the vulnerability of very young women to the STI, requiring early diagnosis through the regular offer of tests such as anti-HIV. It is known that the expansion of the testing offer is configured as an important technical intervention used in order to slow down the occurrence of new HIV infections.[27] As the identification of HIV infection is anticipated, measures to prevent its spread can be intensified, as well as optimized care to increase the life expectancy of people living with the virus.

In addition to these aspects, other understandings triggered by cultural factors may extend to the health condition, for example, the belief that ethnic condition gives you protection and immunity from physical damage.

> *He was infected and his wife too. We told his wife to be careful and she said she wouldn't get AIDS, because she was an Indian.* (n_017)

This idea that she **would not get AIDS because she was an Indian** highlights the strong influences of the Potiguara culture. Although there is a proximity among the villages and Western culture, the way of seeing and reacting to the HIV epidemic is shaped by the customs, beliefs, and practices that still trace the identity of this group. Such conceptions may constitute obstacles, preventing or hindering access to serological testing, prevention, and health care services.[10]

Therefore, the development of preventive actions must focus and consider the representations, values, and practices related to becoming ill. In the case of indigenous populations, the symbolism of the "warrior woman" attributed to Potiguara indigenous women underlies an understanding for some of them of a strong blood that allows a condition of immunity to HIV in this group. Such condition of invulnerability to injuries concerns the constructs of social belonging and represents inheritances of their ancestry.

Therefore, the importance of this debate is highlighted in the construction of political strategies that incorporate subjective elements and have an impact on individual and intimate decisions. That the educational processes are not restricted to scientific information only, but that they make sense to the indigenous people and present adherences to their cultural context.

In general, in the Brazilian scenario insufficient knowledge about the culture of indigenous peoples is a reality in indigenous health districts. Regarding the fight against the STIs, this problem is more significant due to the disarticulation of actions with the local culture. This fact contributes to the widening of vulnerability, since the indigenous health subsystem itself is unprepared to dialog interculturally on a delicate, multifaceted, and difficult to approach topic.[15]

Class 3 - **Need for health education** - retained 19% of the ECUs, being predominantly made up of single women aged between 46 and 59 years old. According to its elements, HIV prevention within the villages requires socialization of information through educational actions,

expansion of dialog, and guidelines. Such resources, mediated by experienced professionals (physicians, nurses, health agents, teachers), may promote the awareness of the indigenous population regarding HIV prevention measures.

> *Prevention helps. If there were more preventive actions to inform, lectures in the community, it would be good. I miss it.* (n_071)

> *Health agents explain to people that it is a disease and that it has no cure and that if it is not taken care of, it can lead to death.* (n_012)

> *Searching for information in health centers, with close people who can provide better information and in schools.* (n_069)

> *At school, we work* [prevention]*, but it is very broad and it needs further reinforcement.* (n_044)

The search for information on HIV prevention mechanisms was also echoed in the testimonies. It is an urgent need, considering the limited resources and few initiatives in the villages. An integrative review study highlighted that HIV prevention actions directed at indigenous tribes have been focused, developed through educational campaigns, counseling, anonymous testing and a psychosocial approach. However, they evidenced difficulties in the implementation of these actions, due to the ethnocultural differences, social conventions, linguistic obstacles, and their traditional healing systems.[10]

In view of the aforementioned demands for more information about HIV prevention, it is believed that the professionals working in health and education can pay attention to the scheduling of educational meetings that address with clarity and creativity the issues surrounding HIV in the villages.

The scarcity of preventive actions for HIV in the villages in Rio Grande do Norte is a significant factor of dissatisfaction among women, who give testimonies in line with the gaps mentioned above.

> *Young people are developing earlier and are not being followed up, nor receiving guidelines to combat this disease.* (n_044)

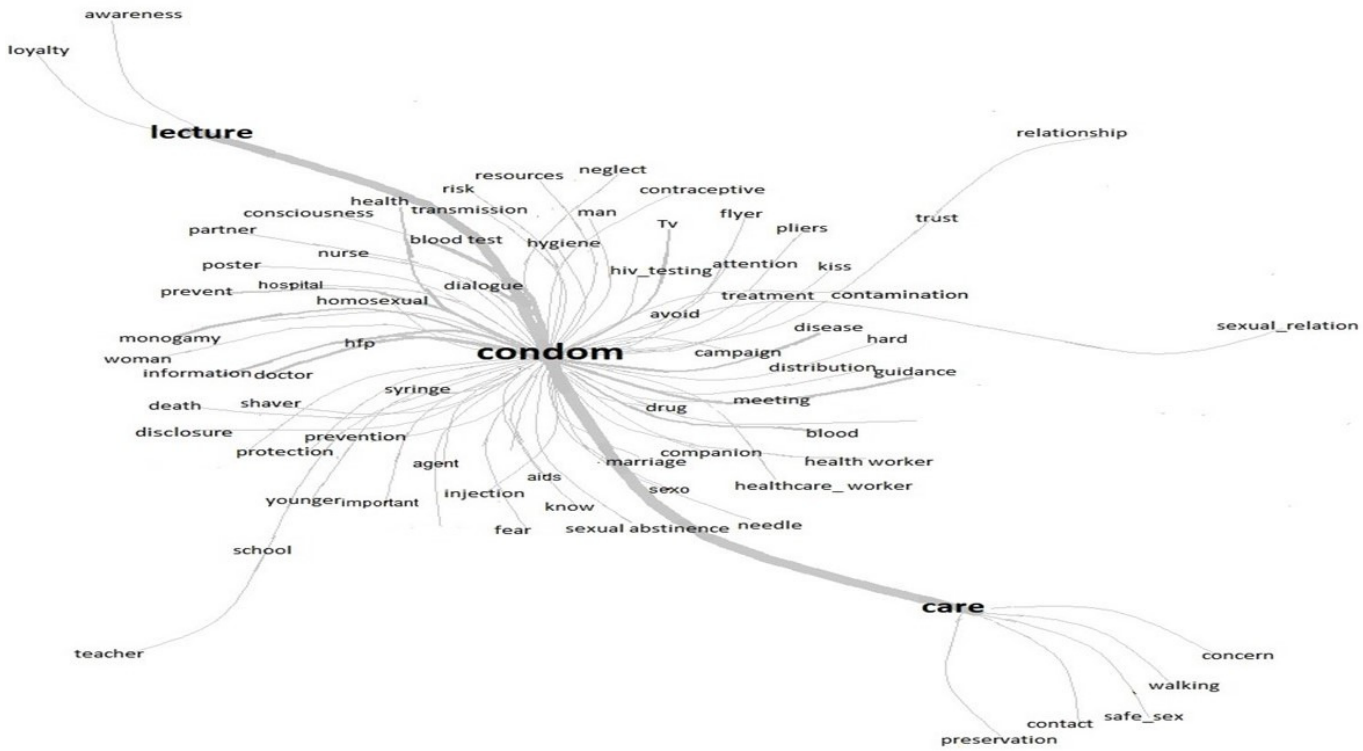
It should be noted that the lack of monitoring and information for young people was mentioned by women belonging to the two largest villages in this investigation: Monte-Mór and Jaraguá, which are configured as those with the largest indigenous population. That said, the need to implement actions related to HIV prevention in the villages is highlighted, with a focus on educational actions that perpetuate information, respecting the beliefs of each indigenous ethnic group. Such measure will possibly mobilize initiatives for the development of professional competences based on interculturality,[29] as well as encouraging self-care in the villages.

The **similarity analysis** described in Figure 2 presented the connections established between the elements of the textual *corpus*, and the interconnection among the words, as well as the level of relation among them. The cognitive reading of the tree made it possible to observe that the preservative element occupied the centrality of the diagram, being characterized as the main HIV prevention resource for indigenous women. The central word had a strong relation with care. This makes sense, since the means of prevention through the use of condoms requires taking care of yourself, in contact with others, a sense of preserving life.

In the same graphic space, the word lecture is presented as a strategy to promote awareness of condom use. Still in the upper right part of the network of connections, the element of trust is present as a device opposing the use of condoms. In an adjacent highlight,

there are light lines that connect the condom to the school, as a promising educational space when linked to the figure of the teacher.

Figure 2 - Similitude Analysis - HIV prevention according to the Potiguara women from Rio Tinto-PB (2018).



Conclusion

Potiguara women configure HIV prevention based on the recognition of the risks of infection, the challenging possibilities of coping, as well as the clear understanding that condoms are an important resource to provide protection against HIV.

They also understand that the discussions and clarifications surrounding HIV infection require attitudes of care, permeated by safe access to information and effective dialog, established between sexual partners and with health and education professionals.

Although there is clarity regarding the risks of infection, there is difficulty in exercising protected sexual practices due to barriers by the partner's resistance to condom use; mistrust of extramarital relationships and difficulty in negotiating the use of condoms in daily life. These obstacles are crossed by issues of social and gender inequality that extend to the reality of other non-indigenous women.

The limitations of the study are related to the fact that it is considered a specific reality. Even though such findings are similar to those identified in the general population, it is not possible to universalize them, given the cultural variations of indigenous peoples.

It is believed that this study may instigate the development of research that focuses on social and cultural contexts, in which interactions and behaviors take place and acquire peculiar meanings. It also reinforces the urgent need for effective responses both in terms of HIV prevention forms, the empowerment of this group to appropriate care and protection attitudes and the training of health professionals, as well as to the formation and motivations and sexual conduct within the indigenous situation.

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