DOI: 10.1590/1413-81232015207.18102014

HIV infection in male adolescents: a qualitative study

Stella Regina Taquette [1]
Adriana de Oliveira Rodrigues [1]
Livia Rocha Bortolotti [1]

Abstract *The gradual reduction in the incidence of AIDS among men who have sex with men has not occurred in the youngest age group; on the contrary, it is growing. This paper examines the vulnerabilities of adolescent males at risk of HIV infection. This is a qualitative study conducted through interviews with HIV positive young men undergoing treatment, whose diagnosis was made during adolescence. The interviews were recorded and transcribed in full. They were analyzed by intensive reading, classified by issues, and interpreted from a hermeneutic-dialectic perspective in dialogue with the literature. We interviewed 16 young men whose diagnosis occurred between the ages of 11 and 19 and for all of them the method of HIV transmission was sexual; 12 of the men were homosexual and 4 were heterosexual. It was evident that vulnerable situations included disbelief in the possibility of contamination, subjection to sex, homophobia and commercial sexual exploitation. This study demonstrates the importance of the formulation of public policies on sexual and reproductive health, which include adolescents and young men. These policies should embody the perspective of masculinity in all its widest aspects, as well as actions in favor of sexual diversity.*

Key words *AIDS, Adolescence, Gender, Homosexuality, Homophobia*

[1] Faculdade de Ciências Médicas, Universidade do Estado do Rio de Janeiro. Av. Prof. Manuel de Abreu 444/2º, Vila Isabel. 20550-170 Rio de Janeiro RJ Brasil. stella.taquette@gmail.com

Introduction

In the current state of the AIDS epidemic in Brazil, the age group of 10-19, i.e. the period of life referred to as adolescence, presents peculiarities in relation to the route of HIV infection. Despite the gradual reduction in the incidence of AIDS among men who have sex with men (MSM), this has not happened among young men who have sex with men (YMSM). In fact, on the contrary, levels among this group are rising[1].

In Brazil, condom use is still low among adolescents[2]. Within the logic surrounding gender in Brazilian society, male adolescents are expected to start their sexual activity at an early age and with the highest possible number of partners in order to prove their manhood, which increases their exposure to the risk of contracting a sexually transmitted disease (STD)[3]. With regard to adolescents of homosexual orientation, the situation is more complex because, in addition to the vulnerabilities that they have as men and young people, they also discover that they have sexual attraction to people of the same sex within a homophobic society. They often isolate themselves, finding it difficult to reveal their feelings to their families and friends, and they do not generally disclose their condition to the health services. This leads to lower levels of protection and higher levels of risk to health. Ministry of Health data indicate homosexual relations as being a factor in vulnerability to HIV in male adolescents, as well as revealing that this group are less educated, have multiple partners, and suffer from co-infections with other STDs[1]

Adolescents of a homosexual orientation find themselves in a position of unequal power in relation to older homosexual men and also heterosexual men. Consequently, they are more exposed to violence, which hinders the negotiation of safe sex[4]. It is worthy of note that public policies in the field of sexual and reproductive health do not favor men, let alone young men and those with a sexuality that differs from the hegemonic standard; their rights are not recognized[5,6].

Taking the above into consideration, this article aims to examine the vulnerabilities of adolescent and young HIV positive males at risk from HIV infection, through their own perceptions. It is our intention to contribute to public policies in combating the HIV/AIDS epidemic within the adolescent age group.

Methods

The target population of this study was HIV positive young men whose diagnosis occurred in adolescence. We chose a qualitative method, given the nature of the object of study. The data were collected in an intersubjective environment through semi-open interviews. The interview is a privileged instrument: it allows us to know, through the speech of interlocutors, the value system of a social group, revealing its structural conditions and, at the same time, transmitting representations of that group in specific historical, socioeconomic and cultural conditions[7]. The sample was intentional, consisting of HIV positive men and adolescents undergoing treatment.

The Brazilian Ministry of Health provides free and universal access to antiretroviral therapy for AIDS patients and the municipality of Rio de Janeiro has 43 public health services to serve this sector of the public. These include general hospitals that provide assistance to large numbers of varied individuals who come from various neighborhoods. To reflect this plurality of individuals, we recruited potential research participants from the following hospitals: Hospital Universitário Pedro Ernesto, Hospital Gaffrée Guinle, Hospital Universitário Clementino Fraga Filho and Hospital Federal dos Servidores do Estado. These hospitals meet the needs of people from various social classes, but mostly those of lower socioeconomic status. The health services were contacted by the research team, which was composed of a doctor, a social worker and a nurse and, after approval by the ethics committee and the consent of the participants (and those responsible for participants under the age of 18), the data collection started.

The criteria for inclusion were a diagnosis between the ages of 10 and 19 and a period of illness of up to five years, to ensure homogeneity in the group regarding the duration of illness. The adolescents and young men who met this profile were sent to interviewers by health professionals who attended them in the health services. The individuals who agreed to participate were informed of the content of research and if they were in agreement they were interviewed in a private environment. To complete the sample, the team attended these hospitals at least twice a week for 18 months. The end of the data collection occurred when we considered that there was

Ciência & Saúde Coletiva, 20(7):2193-2200, 2015

a saturation of the information that had been gathered. The long period of time for interviewing was due to the fact that the interviewers did not have availability to carry out this work full-time on a daily basis at the health centers, and also because there was difficulty and delay in obtaining authorization to conduct the study in one of the chosen hospitals.

The interviews followed a script, with questions about demographic, family, sexual history and infection/diagnosis information. The authors recorded and transcribed the interviews in full. From the beginning, and throughout the study, the analysis of textual data from the transcripts was conducted, comprising the steps of reading and re-reading the texts to provide a singular view of each interview as well as a cross-reading of all the texts to identify what was common to the narratives, as well as the differences, in order to understand what was the most relevant content. We subsequently sought to identify the meanings attributed by the individuals to the questions that were asked, trying to understand the internal logic of this group in a comparative dialogue with the literature. Finally, an interpretative summary was prepared that responded to the research questions.

The research met the ethical principles contained in the Declaration of Helsinki and was approved by the Research Ethics Committee of the Municipal Health Secretary of Rio de Janeiro on 9/11/2009. All the interviewees, and those responsible for participants under the age of 18, signed a free and informed consent form.

Results and discussion

Characterization of the group

The data were collected between July 2010 and December 2011 and the sample consisted of 16 individuals. An interview, which averaged fifty minutes, was conducted with each interlocutor. The main characteristics of the interviewees were as follows: low socioeconomic level with an average family income of 3.5 minimum wages (variation of 1 to 10 salaries); 12 were homosexual and 4 were heterosexual; a majority were non-white and half of them were more than two years behind in schooling. The average age of the first incidence of sexual relations was 14 (from 12-18) and the median age was 15 years. For the majority (68.7%) this occurred at the age of 15 years or older. In 93.7% of cases these sexual partnerships were relationships without emotional involvement ("one night stands" and abuse). Only one interviewee reported that they had been infected by a girlfriend. Multiple sexual partnerships (over 4 in the last year) were reported by 81.3% of the interviewees and 62.5% reported that they had prostituted themselves.

The families of the interviewees were mostly single parent. There were common reports of conflicts and family violence, as well as the fragmentation of the family because of socioeconomic difficulties, with family members living with other relatives, grandparents, uncles, cousins etc.

The data were classified into four categories, which, incorporating the factors of multiple sexual partnerships and inconsistent condom use, were configured into the following categories of experiences of vulnerability: disbelief in the possibility of HIV transmission, subjection to sex, homophobia and commercial sexual exploitation.

Disbelief in the possibility of HIV transmission

The narratives of our interlocutors showed that they did not believe that they could be contaminated by HIV, despite the absence of self-care and safety during sexual relations. This fact corresponds to the characteristic considered by some thinkers in the field of psychology to be normal during adolescence. According to seminal authors like Jean Piaget[8], from the perspective of the development of intelligence the capacity for abstract thinking, i.e. the ability to hypothesize and to think about the consequences of one's acts, occurs from adolescence onwards, and conversely children think in a concrete way. The risky behavior adopted by some adolescents, such as having unprotected sex and believing that nothing will happen to them, can be partly attributed to this difficulty in being able to think in an abstract manner. This characteristic, which is sometimes referred to as magical thinking is part of the 'normal syndrome' of adolescence, as well as impulsive behaviour and the need to fantasize. It is a resource that is used unconsciously in order not to incorporate knowledge about reality that will bother adolescents, and which contributes to their inability to evaluate the consequences of their own acts, among other things[9]. The words of our interlocutors enabled us to perceive those characteristics, which are considered to be typical of this stage of growth and development, when

they expressed their disbelief about the possibility of HIV transmission:

Sometimes I wore a condom and sometimes I didn't, it depended more on the woman. Sometimes I remembered and sometimes I didn't, I though the person was OK about it.

At the time there is so much excitement, they say that they aren't going to use one, and then you do it without one.

The feelings expressed in the words above show that adolescents act without thinking and engage in risky activities[10]. They are more vulnerable to the influences of the social environment and they assimilate news without much reflection[11]. Research by Dessunti and Advincula[12] with Brazilian university students in the health field corroborates our data in identifying the perception of invulnerability (assessed by the degree of concern/ anxiety related to the danger of acquiring STDs/AIDS) as representing a risk factor in relation to STDs/AIDS.

The references to condom use showed that they were little used or used incorrectly. Several interviewees reported that condoms burst during sexual activity, that they were bothered by using a condom, or that their partner simply didn't want to use one. Many interviewees also stated that having condoms did not guarantee that they would use them. Others complained of poor access to condoms and suggested that they should be more easily available.

Subjection to sex

We include two different situations in this category, but both result in what we understand to be subjection or submission to sex, i.e. when sexual relations occur without the individual having power or a conscious choice in relation to the sexual act, thereby constituting a situation of vulnerability to STDs. The first refers to the implementation of hegemonic gender patterns and the second refers to cases of sexual abuse.

Hegemonic gender patterns within society expose men to the risk of sexually transmitted infections and this is associated with early sexual initiation, the multiplicity of sexual partners without emotional involvement, and homosexuality. What is meant by being a man or woman in contemporary society, i.e. the expected behavior for each sex, is currently in a situation of flux but the inequality of power between the sexes is still great, especially in the poorest social classes from the economic point of view and also in terms of education. For men, sexual activity is desired and stimulated from an early age. For women, it is expected that will wait and that they will be 'conquered' by men. Consider some of the following statements from our interlocutors:

I have had many women; I began at a very young age.

Every day I had a different one (sexual partner).

Let me see, well I'm no rabbit (laughs) but I'm also not a saint.

Oh, I've lost count (of the number of sexual partners).

We still live under the aegis of compulsory heterosexuality, a social norm that is constituted by mandatory heterosexuality, and which constructs a necessary and consistent relationship between gender identity, desires, and sexual practices. It is this normativity that informs the conventions of gender and sexuality in our society, which is marked by an asymmetry between the male and the female[13]. As a result, these conventions can translate into practical experiences of sexual life, into submissive relationships, and the control of sexuality. They can also result in relationships of gender violence and create obstacles in negotiating the use of condoms[14]. In the case of YMSM, because the female sex is considered to be inferior and subordinate, men who take on the 'non-masculine' gender also become objects of domination, and therefore of being subjected to sex[4].

As adolescents, individuals are generally more vulnerable to external influences from their peers and society itself. These standards impose behavior norms, from which it is difficult for them to escape without feeling inadequate and not being accepted. For example, when they refer to the feelings that result from their first sexual experience, an experience which is so encouraged and desired by men, and also when they refer to the numbers of sexual partners that they have had[15,16].

The second situation that falls into this category refers to the experiences reported by our interviewees regarding victimization in situations of explicit violence. The YMSM we interviewed reported submission to sexual partners as well as abuse perpetrated by older men, as evidenced in the following extracts:

... Because at that time I did not really know what love was [...] *I was very silly and he was an older person in his early thirties, I was 17. That was when he actually used me, you know.*

[When] *he abused me, I was 16, 15 going on 16.*

My uncle, I was young, I don't know how it started. He started touching me.

Ciência & Saúde Coletiva, 20(7):2193-2200, 2015

An important fact is that homosexual relations are also marked according to this system of gender relations and they are, at least in principle, structured on a macho model that is based on gender hierarchy through lines of activity and passivity. Passive or effeminate men assume the symbolic role of women, and they are subjected to forms of domination.

Homophobia

The prevailing heteronormativity in society determines the rules of hegemonic gender and it is the main root of homophobia, which is a violent rejection of diverse forms of sexuality. In this social context, adolescents with homosexual attractions may have concerns arising from these homoerotic feelings. The latter are usually dramatic and veiled due to fear of rejection[17,18]. It is hard for an adolescent to accept their homosexuality, so in order to defend themselves from homophobia many homosexuals do not expose themselves and they isolate themselves due to a fear of revealing themselves and sharing this suffering with another person.

The young people interviewed in this study mentioned the strangeness and the inadequacy of the behavioral patterns that they experienced after they realized that they had homosexual feelings. When they had their first homosexual experiences they were overwhelmed with strong feelings of guilt, which may have been due to internalized homophobia[19]. The suffering that arises from these situations is intense and often leads to social isolation with disastrous consequences for adolescents, such as STDs, depression and even suicide[20,21]. Suffering from discrimination, often in their own families, and social rejection these individuals often choose to leave home and live in ghettos that are referred to by some as the 'gay world', where they feel more accepted and start to adopt the behavior of these groups. The narratives of the YMSM interviewees referred to intra-family homophobia and exposure to health risks when they experience the 'gay world', where they often have unprotected sex with multiple partners[22].

I have only been really living for the last seven years. I needed and wanted to live my life for myself, because I'm gay I didn't have my freedom to be with my partner, I even had a steady partner.

My father couldn't accept the fact that I am gay... They beat me up when I was diagnosed with HIV.

In the gay world if you have a condom you use it, if you don't you still have sex anyway. At parties or casual encounters people have intercourse without a condom.

If a man touched me in a nightclub and I wanted it, I went ahead and did it.

As in social relations between homosexuals and heterosexuals, sexual practices are socially and culturally constructed within the context of sexual guidelines that are learned throughout the development and growth of an individual throughout their lives. Homosexual adolescents tend to be sexually initiated at an early age and they have more sexual partners than heterosexuals. Sexual experimentation may be the most accessible way to learn how to be gay.

Other factors related to homophobia heighten this risk; for example, the great limitation in access to social protection and health services and the marginality that leads some to the sex trade and abuse of alcohol and drugs.

Several studies have shown the greater vulnerability of adolescent and young gay people[1,23-25]. Despite the fact that these people perceive themselves as vulnerable to HIV infection they do not consistently use condoms and they have multiple partners. It is a great challenge to identify and understand the particularities of the exercise of sexuality of this group in the fight against AIDS[26,27].

Commercial sexual exploitation

Another context of vulnerability that was observed among young HIV positive people in this study was that of commercial sexual exploitation. The main motivation for adolescents to engage in this activity is the search for economic advantages[28]. For some adolescents, having sex with other men does not make them feel less like men because, in general, they are active in the activity, which gives them a position of virility. They do not tend to use condoms in oral sex because they do not see it as hazardous.

For gay adolescents who suffer discrimination the sex trade is often the only way out for those who live on the margins of society with little access to social protection, education and work[29]. Missed schooling is common in homosexual adolescents due, among other factors, to bullying. Sometimes they are unable to put up with the aggression and they drop out of school. Low levels of education are reflected in worse professional qualifications, and therefore less chance in the labor market, resulting in very few formal employment options for these young people.

In the accounts of the interviewees who reported that they had sex for money we detected

a certain naturalization about the act of prostitution, which masked the violence contained in prostitution, both structurally, and in terms of the resulting inequality of power between the perpetrator and the prostituted adolescent. Although it is sexual abuse, it is often not perceived by these adolescents as such. Consider the following extracts:

I've done prostitution, I'm bisexual. I had to do everything at that time and because of that I got sick. I had several partners, I lost count.

So I wore a condom, but sometimes the client didn't want to use one. I said that he had to pay more, so he paid more, and I didn't use one.

It was necessity that led me to prostitution. My family was poor; we had almost no money, not even for food. Then I found myself desperate, I went and met a friend...

I made a living by being a prostitute. We did not choose, we would do it with anyone.

The dynamics of the AIDS epidemic has shown the increasing involvement of segments of the population with lower purchasing power[1,30] and the young people who engage in prostitution are generally found in particularly unfavorable positions with low socioeconomic status and levels of education. The clandestine nature that characterizes commercial sexual exploitation, coupled with relationships with multiple partners, leads the young people involved in prostitution to be more vulnerable to infection by STDs and AIDS.

Final considerations

Thinking about the AIDS epidemic, and evaluating it under the parameter of the contexts of vulnerability, we consider that the sector of the population that we interviewed provided evidence of situations in which public policies need to focus on individual, social and programmatic dimensions, all of which are interrelated.

From an individual standpoint, our interlocutors demonstrated low levels of self-care. They require better information and the availability of condoms, among other things. However, the information they require is not limited to issues related to HIV infection, but mainly regarding increased schooling. Condoms should be available on a large scale in the various environments frequented by adolescents and they should be free and available in an un-bureaucratic way. The Health and Prevention in Schools Program, which is a partnership between the Ministry of Health and the Ministry of Education, contains activities to promote the sexual and reproductive health of adolescents and young people in schools; it is a public policy and it should be increased[31]. The educational approach has been successful in generating positive changes in the sexual behavior of adolescents and should be encouraged[32]. In France, where the prevalence of AIDS in the adolescent age group is proportionally three times lower than in Brazil, sex education activities and the distribution of condoms in schools are required by law[33].

From a social standpoint, several challenges need to be tackled to reduce AIDS among adolescents; these include social inequality, structural and gender violence, and homophobia. These problems have already been the subject of interventions by various sectors of society and the latter should be expanded and intensified. Another issue worth noting is the early sexualization that turns many young adolescents into victims. In their eagerness to be accepted in the groups to which they belong they end up starting to have sex at an early age because this is expected of them. They frequently become considered as objects among their peers and often have unprotected sex, rather than being individuals aware of their own sexuality. It is necessary to encourage this debate in Brazil, especially in the educational field. In Brazil, the average age at which adolescents in urban areas have their first sexual experience is around 14.9[34]. In developed countries such as France, this average is about 18[35].

From a programmatic standpoint, our study demonstrated the need to invest in the effective inclusion of adolescent young men in health programs and services, including actions to meet the specific needs of the YMSM population. Health professionals should be trained to deal with sexual diversity. It is known that access to skilled health care for this population is proven to prevent risky behavior[36]. Male sexuality, in relation to men's health, must be addressed from a gender perspective, given that the reduced involvement of the YMSM population and the attendant problems that they experience occurs because of models of masculinity[37].

Finally, it is worth noting that our study only included adolescents and young people from the less-privileged (from an economic point of view) social classes. Consequently, the study dealt with a section of the population that most uses public health services and that is currently the most affected by AIDS, which limited the scope of our results. We would stress the importance of future research to study individuals from more affluent

social strata in order to expand the understanding of different contexts of vulnerability.

Collaborations

SR Taquette participated in drafting the study, in collecting and analyzing the data, and in the writing and final revision of the manuscript. AO Rodrigues and LR Bortoloti collaborated in the collection and analysis of data and the final revision of the manuscript.

Acknowledgements

This research received funding from Faperj and the authors would like to thank Dr. Eduardo Pozzobon from the Hospital Universitário Pedro Ernesto, Dr. Norma de Paula Motta Rubini from the Hospital Gaffrée Guinle, Dr. Alberto Chebabo from the Hospital Universitário Clementino Fraga Filho, and Dr. Jacqueline Anita Menezes from the Hospital Federal dos Servidores do Estado for collaborating in conducting this study.

References

1. Brasil. Ministério da Saúde. Departamento de DST, AIDS e Hepatites Virais. *Boletim epidemiológico* 2014 [acessado 2014 ago 15]. Disponível em: http://www.aids.gov.br/sites/default/files/anexos/publicacao/2013/55559/_p_boletim_2013_internet_pdf_p__51315.pdf
2. Brasil. Ministério da Saúde (MS). Departamento de DST, Aids e Hepatites Virais. *Pesquisa de conhecimentos, atitudes e práticas 2009*. [acessado 2014 ago 11]. Disponível em: http://www.aids.gov.br/pagina/pesquisa-de-conhecimentos-atitudes-e-praticas-relacionadas-dst-e-aids
3. Barker G. A saúde do homem adolescente: aplicando uma perspectiva de gênero ao masculino. In: Brasil. Ministério da Saúde (MS). *Saúde do adolescente: competências e habilidades*. Brasília : Editora do Ministério da Saúde; p. 223-230, 2008. [acessado 2014 maio 11]. Disponível em: http://portal.saude.gov.br/portal/arquivos/pdf/saude_adolescente.pdf
4. Faleiros E. Violência de gênero. In: Taquette SR. *Violência contra a mulher adolescente / jovem*. Rio de Janeiro: Ed. UERJ; 2005. p. 61-11.
5. Brasil. Ministério da Saúde (MS). Departamento de Atenção Básica. Secretaria de Atenção à Saúde. Departamento de ações Programáticas Estratégicas. *Política Nacional de Atenção Integral à Saúde do Homem (Princípios e Diretrizes)*. Brasília, novembro de 2008. [acessado 2014 ago 15]. Disponível em: http://dtr2001.saude.gov.br/sas/PORTARIAS/Port2008/PT-09-CONS.pdf
6. Silva CG, Paiva V, Parker R. Juventude religiosa e homossexualidade: desafios para a promoção da saúde e de direitos sexuais. *Interface (Botucatu)* 2013; 17(44):103-117.
7. Minayo MCS. *O desafio do conhecimento. Pesquisa qualitativa em saúde*. 13ª ed. São Paulo: Hucitec; 2013.
8. Piaget J. Intelectual evolution from adolescence to adulthood. *Human Dev* 1972; 15:1-12.
9. Aberastury A, Knobel M. *Adolescência normal*. Porto Alegre: Artes Médicas; 1988.
10. Quadrel MJ, Fischhoff B, Davis W. Adolescent (In)vulnerability. *Am Psychol* 1993; 48(2):102-116.
11. Borges ALV. Pressão social do grupo de pares na iniciação sexual de adolescentes. *Rev. esc. Enferm. USP* 2007; 41(N. Esp.):782-786.
12. Dessunti EMR, Advincula AO. Fatores psicossociais e comportamentais associados ao risco de DST/AIDS entre estudantes da área de saúde. *Rev. Latino-Am. Enfermagem* 2007; 15(2):267-274.
13. Butler J. *Problemas de gênero. Feminismo e subversão da identidade*. Rio de Janeiro: Civilização Brasileira, 2003.

14. Monteiro DLM, Trajano AJB, Katia SS, Russomano FB. Incidence of cervical intraepithelial lesions in a population of adolescents treated in public health services in Rio de Janeiro, Brazil. *Cad Saude Publica* 2009; 25(5):1113-1122.
15. Gubert D, Madureira VSF. Iniciação sexual de homens adolescentes. *Cien Saude Colet* 2008; 13(Supl. 2):2247-2256.
16. Gonçalves H, Béhague DP, Gigante DP, Minten GC, Horta BL, Victora CG, Barros FC. Determinantes sociais da iniciação sexual precoce na coorte de nascimentos de 1982 a 2004-5, Pelotas, RS. *Rev Saude Publica* 2008; 15(2):267-274.
17. Teixeira FS, Marreto CAR, Mendes AB, Santos EN. Homofobia e sexualidade em adolescentes: trajetórias sexuais, riscos e vulnerabilidades. *Psicol. cienc. prof.* 2012; 32(1):16-33.
18. Pocahy FA, Nardi HC. Saindo do armário e entrando em cena: juventudes, sexualidades e vulnerabilidade social. *Rev. Estud. Fem.* 2007; 15(1):45-66.
19. Blais M, Gervais J, Hebert M. Homofobia internalizada como mediador parcial do bullying homofóbico e autoestima entre jovens de minorias sexuais em Quebec (Canadá). *Cien Saude Colet* 2014; 19(3):727-735.
20. Remafedi G. Adolescent Homosexuality: Dare We Ask the Question*? Arch Pediatr Adolesc Med* 2006; 160(12):1303-1304.
21. Teixeira-Filho FS, Rondini CA. Ideações e Tentativas de Suicídio em Adolescentes com Práticas Sexuais Hetero e Homoeróticas. *Saúde Soc*. 2012; 21(3):651-667.
22. Rios LF. Parceiros e práticas sexuais de homossexuais jovens no Rio de Janeiro. *Cad Saude Publica* 2003; 19(Supl. 2):S223-S232.
23. Szwarcwald CL, Andrade CLT, Pascom ARP, Fazito E, Pereira GFM, Penha IT. Práticas de risco relacionadas à infecção pelo HIV entre jovens brasileiros do sexo masculino, 2007. *Cad Saude Publica* 2011; 27(Supl. 1):s19-s26.
24. Guenter-Grey CA, Varnell S, Wiser JL, Mathy RM, O'Donnell J, Stuev A, Remafedi G; Community Intervention Trial for Youth Study Team. Trends in Sexual Risk-Taking among Urban Young Men Who Have Sex with Men, 1999-2002. *J Natl Med Assoc* 2005; 97(5):38S-43S.
25. Beloqui JA. Relative risk for AIDS in homo / bisexual and heterosexual. *Rev Saude Publica* 2008; 42(3):437-442.
26. Andrade SMO, Tamaki EM, Vinha JM, Pompilio MA, Prieto CW, Barros LM, Lima LB, Chaguri MC, Pompilio SAL. Vulnerabilidade de homens que fazem sexo com homens no contexto da AIDS. *Cad Saude Publica.* 2007; 23(2):479-482.
27. Fields E, Bogart LM, Smith KC, Malebranche DJ, Ellen J, Schuster MA. HIV Ris and Perceptions of Masculinity Among Young Black Men Who Have Sex With Men. *J Adolesc Health* 2012; 50(3):296-303.
28. Taquette SR, Matos HJ, Rodrigues AO, Bortolotti LR, Amorim E. A epidemia de Aids em adolescentes de 13 a 19 anos no município do Rio de Janeiro: descrição espaço-temporal. *Rev Soc Bras Med Trop* 2011; 44(4):467-470.
29. Santos MA. Prostituição masculine e vulnerabilidade às DST/AIDS. *Texto Contexto Enferm* 2011; 20(1):76-84.
30. Parker R, Camargo Júnior KR. Pobreza e HIV/AIDS: aspectos antropológicos e sociológicos. *Cad Saude Publica* 2000; 16(Supl. 1):S89-S102.
31. Brasil. Ministério da Saúde (MS). *Diretrizes para implantação do Projeto Saúde e Prevenção nas Escolas*. Brasília: MS; 2006.
32. Andrade HHSM, Mello MB, Sousa MH, Makuch MY, Bertoni N, Faúndes A. Mudanças no comportamento sexual de adolescentes de escolas públicas no Brasil após um programa de educação sexual. *Cad Saude Publica* 2009; 25(5):1168-1176.
33. Taquette SR. Epidemia de HIV/Aids em adolescentes no Brasil e na França: semelhanças e diferenças. *Saude Soc*. 2013; 22(2):618-628.
34. Paiva V, Calazans G, Venturi G, Dias R. Idade e uso de preservativo na iniciação sexual de adolescentes brasileiros. *Rev Saude Publica* 2008; 42(Supl.1):45-53.
35. Moreau C, Lydié N, Warszawski J, Bajos N. Activité sexuelle, IST, contraception stabilisée. In: Beck François, Guilbert Philippe, Gautier Arnaud. Baromètre santé 2005 Attitudes et comportements de santé. France: INPES; 2007.p.328-353.
36. Kipke MD, Kubicek K, Weiss G, Wong C, Lopez D, Iverson E, Ford W. The Health and Health Behaviors of Young Men Who Have Sex with Men. *J Adolesc Health* 2007; 40(4):342-350.
37. Schraiber LB, Figueiredo W dos S, Gomes R, Couto MT, Pinheiro TF, Machin R, Silva GS, Valença O. Health needs and masculinities: primary health care services for men. *Cad Saude Publica* 2010; 26(5):961-970.

Article submitted 19/8/2014
Approved 13/11/2014
Final version submitted 15/11/2014