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**INTERVENÇÕES VOLTADAS AO USO DO PRESERVATIVO POR
ADOLESCENTES EM SITUAÇÃO DE RUA: REVISÃO SISTEMÁTICA E
METÁNALISE**

FORTALEZA

2022

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Dissertação apresentada ao Programa de Pós-Graduação em Enfermagem, da Universidade Federal do Ceará, para defesa, como parte para obtenção do Título de mestre em Enfermagem.

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A Deus pela vida e seu amor inquestionável
A minha amada mãe Ivaneide da Silva dos Santos
que é meu alicerce, minha fortaleza, meu amor
maior.
Á minha irmã, Ana Cláudia da Silva dos Santos que
é minha *soul mate* e minha maior “*torcedora*”.

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Precisamos resistir e insistir ao lado dos indesejáveis e descartados, e com eles, gritar sem cessar para que sejam ouvidos.

Padre Julio Lancellotti

RESUMO

As intervenções em saúde visam melhorar as condições de vida das pessoas, grupos ou populações. Neste estudo, as intervenções direcionadas ao uso do preservativo, no âmbito da saúde sexual a prevenção das IST/HIV/Aids foram o foco. Nesta perspectiva, este estudo teve objetivo de analisar a literatura científica quanto a eficácia de intervenções em saúde para uso do preservativo por adolescentes em situação de rua. Trata-se de uma revisão sistemática de ensaios clínicos e estudos observacionais, embasada pelas recomendações da *Cochrane Collaboration*. O acrônimo PICOS foi usado na construção da questão norteadora, sendo esta: Intervenções educativas e/ou de cuidados em saúde são eficazes para promover o uso do preservativo por adolescentes em situação de rua? As estratégias de busca específicas foram aplicadas nas bases de dados eletrônicas Medline, *Cochrane Central Register of Controlled Trials* (CENTRAL), PsycINFO, Scopus, EMBASE, *Web of Science*, CINAHL, LILLACS e BDENF, sem restrição de data e de idioma. A busca, avaliação da elegibilidade e extração de dados dos estudos foi realizada de forma independente por dois revisores, para tanto os softwares Rayyan e ENDNOTEweb foram usados no cegamento e gerenciamento das referências. A análise da viabilidade e validade dos estudos seguiu o *Cochrane Handbook*, com o software *Review Manager 5.4.1* utilizado para análise estatística e o software *GRADEpro* para produzir perfis de evidência GRADE. A Avaliação do risco de vies foi feita através dos instrumentos da *Cochrane's Collaboration Tool* para ensaios clínicos randomizados e o NEWCASTLE-OTTAWA SCALE para estudos observacionais. As principais categorias de intervenções aplicadas aos adolescentes em situação de rua incluíram: Sessões de aconselhamento, Programas multiestratégias (terapia individual e familiar - terapia cognitivo-comportamental, entrevista motivacional, terapia familiar, gerenciamento de casos), e Reforço comunitário. Seis estudos foram inseridos na metanálise. Por meio do Q de Cochran observou-se diferença significativa entre os estudos $Q(5)=13,1; p=0,02$; além disso, a análise apresentou $I^2=62\%$, ambos indicativos de heterogeneidade. Dessa forma, escolheu-se o modelo de efeitos aleatórios. Assim, por meio da metanálise evidenciou-se que as intervenções aumentaram o uso de preservativo em 28% (IC95%: 1,07 – 1,54; $p<0,01$). Dessa forma, as intervenções educativas aumentam/estimulam o uso do preservativo entre adolescentes em situação de rua, com destaque para as baseadas em aconselhamento como as mais eficazes. Os achados narrativos destacam que: o aconselhamento é uma estratégia psicoeducativa que deve ser

realizada sob um modelo de atenção centrado no adolescente, integral e integrado. Os programas multiestratégias mostram-se opções promissoras ao empregar metodologias comportamentais e geracionais que tem potencial de gerar mudança de condutas e no estilo de vida. O Reforço Comunitário, configuram-se como um pacote abrangente de tratamento comportamental que ajuda as pessoas a descobrir e adotar um estilo de vida prazeroso e saudável. Enfim, conclui-se que todas as estratégias contribuem, no limiar do seu escopo e eficácia, para melhorar as práticas sexuais seguras de adolescentes em situação de rua.

Palavras-chave: Enfermagem. Adolescente. Revisão Sistemática. Educação em saúde. Pessoas em situação de Rua.

ABSTRACT

Health interventions aim to improve the living conditions of people, groups or populations. In this study, interventions aimed at condom use, within the scope of sexual health and the prevention of STI/HIV/Aids were the focus. In this perspective, this study aimed to analyze the scientific literature regarding the efficacy of health interventions for condom use by street adolescents. This is a systematic review of clinical trials and observational studies, based on the recommendations of the Cochrane Collaboration. The acronym PICOS was used in the construction of the guiding question, which is: Are educational and/or health care interventions effective in promoting condom use by street adolescents? Specific search strategies were applied to Medline, Cochrane Central Register of Controlled Trials (CENTRAL), PsycINFO, Scopus, EMBASE, Web of Science, CINAHL, LILLACS and BDENF electronic databases, without date or language restrictions. The search, eligibility assessment and data extraction from the studies were performed independently by two reviewers, for both Rayyan and ENDNOTEweb software were used in the blinding and management of references. The analysis of the feasibility and validity of the studies followed the Cochrane Handbook, with Review Manager 5.4.1 software used for statistical analysis and GRADEpro software to produce GRADE evidence profiles. The risk of bias assessment was performed using the instruments of Cochrane's Collaboration Tool for randomized clinical trials and the NEWCASTLE-OTTAWA SCALE for observational studies. The main categories of interventions applied to homeless adolescents included: Counseling sessions, Multi-strategy programs (individual and family therapy - cognitive behavioral therapy, motivational interviewing, family therapy, case management), and Community Reinforcement. Six studies were included in the meta-analysis. By means of the Cochran's Q, a significant difference was observed between the studies $Q(5)=13.1$; $p=0.02$; in addition, the analysis showed $I^2=62\%$, both indicative of heterogeneity. Thus, the random effects model was chosen. Thus, through the meta-analysis, it was shown that the interventions increased condom use by 28% (95%CI: 1.07 – 1.54; $p<0.01$). In this way, educational interventions increase/encourage condom use among street adolescents, with emphasis on counseling-based interventions as the most effective. The narrative findings highlight that: counseling is a psychoeducational strategy that must be carried out under an adolescent-centered, integral and integrated care model. Multistrategy programs are promising options when employing behavioral and generational

methodologies that have the potential to generate changes in behavior and lifestyle. Community Reinforcement is a comprehensive behavioral treatment package that helps people discover and adopt a pleasurable and healthy lifestyle. Finally, it is concluded that all strategies contribute, at the threshold of their scope and effectiveness, to improve safe sexual practices of street adolescents.

Keywords: Nursing. Adolescent. Systematic review. Health education. Homeless.

LISTA DE FIGURAS

Figura 1: Fluxograma com itinerário metodológico aplicado na RS.

Figura 2: Fluxograma de seleção dos estudos pela metodologia PRISMA (PAGE *et al.*, 2020)

Figura 3: Metánalise das intervenções educativas para promoção do uso do preservativo entre adolescentes em situação de rua

Figura 4: Risco de enviesamento das intervenções educativas para promoção do uso do preservativo entre adolescentes em situação de rua

LISTA DE QUADROS

Quadro 1: Descrição das intervenções educativas quanto a seus conceitos

Quadro 2: Descrição dos termos e assuntos de interesse utilizados na revisão

QUADRO 3 - Estratégias de busca, conforme as bases de dados e os vocabulários controlados, utilizadas na RS

Quadro 4: Características definidoras dos níveis de enviesamento de estudos de acordo com a *Cochrane's Collaboration Tool*

QUADRO 5: Características dos estudos incluídos quanto a referência, país, tipo de estudo, cenário, amostra, sexo e idade dos participantes

Quadro 6: Caracterização das intervenções dos estudos incluídos quanto a referência, periodização e descrição das intervenções.

Quadro 7: Qualidade metodológica dos ECR incluídos de acordo com a ferramenta *Cochrane Risk of Bias*

Quadro 8: Qualidade metodológica dos ECR incluídos de acordo com a ferramenta *NEWCASTLE - OTTAWA QUALITY ASSESSMENT SCALE*

Quadro 9: Avaliação dos perfis de evidência GRADE

Quadro 10: Descrição dos estudos com intervenção baseada em aconselhamento quanto a referência, aos desfechos e implicações clínicas

Quadro 11: Descrição dos estudos com intervenções baseadas terapia cognitivo-comportamental (TCC), motivacional entrevista (MI), terapia familiar e gerenciamento de casos quanto a referência, aos desfechos e implicações clínicas.

Quadro 12: Descrição dos estudos com intervenção baseada na terapia comunitária quanto a referência, aos desfechos e implicações clínicas.

LISTA DE ABREVIATURAS E SIGLAS

BDENF - Banco de Dados em Enfermagem

CENTRAL - *Cochrane Central Register of Controlled Trials*

CINAHL - *Cumulative Index to Nursing and Allied Health Literature*

ECR – Ensaio clínico randomizado

EMBASE - *Excerpta Medica Database*

ES - Educação em saúde

HIV - Vírus da imunodeficiência humana

IBGE - Instituto Brasileiro de Geografia e Estatística

IPEA - Instituto de Pesquisa Econômica Aplicada

IS - Intervenções em saúde

IST – Infecção sexualmente transmissível

LILLACS - Literatura Latino-americana e do Caribe em Ciências da Saúde

Medline - *Medical Literature Analysis and Retrievel System Online*

OMS - Organização Mundial de Saúde

ONG - Organização não Governamental

ONU - Organização Nacional das Nações Unidas

PEP - Profilaxia Pós-Exposição

PrEP - Profilaxia Pré-Exposição

PSR -População em Situação de Rua

PsycINFO - *Psychological Abstracts, American Psychological Association, APA*

RS - Revisão sistemática

SUS -Sistema Único de Saúde

SUMÁRIO

| | |
|---|----|
| 1. INTRODUCÃO | 17 |
| 2. OBJETIVOS | 20 |
| 2.1 Geral | 20 |
| 2.2 Específicos..... | 20 |
| 3. REFERENCIAL TEÓRICO | 21 |
| 3.1 Caracterização das intervenções de saúde para uso do preservativo | 21 |
| 3.2 Intervenções Educativas - IE | 22 |
| 3.3 Intervenções de Cuidado em Saúde - ICS..... | 25 |
| 3.4 Caracterização da população adolescente em situação de rua..... | 27 |
| 3.5 Saúde sexual e adolescência | 28 |
| 4. MÉTODO..... | 31 |
| 4.1 Factibilidade e concepção..... | 33 |
| 4.1.1 Questão norteadora | 33 |
| 4.1.2 Bases de dados | 33 |
| 4.2 Definição de critérios amostrais e de elegibilidade | 36 |
| 4.2.1 Delineamento e participantes dos estudos | 36 |
| 4.2.2 Comparadores | 37 |
| 4.2.1 Intervenções de interesse | 37 |
| 4.3 Seleção dos estudos | 37 |
| 4.3.1 Rayyan / Endnote..... | 37 |
| 4.3 Extração de dados | 38 |
| 4.3.1 Formulário de extração de dados de interesse | 38 |
| 4.4 Avaliação de risco de viés | 39 |
| 4.4.1 Cochrane's Collaboration Tool/ NEWCASTLE-OTTAWA SCALE (NOS) | 39 |
| 4.5 Síntese de dados | 41 |
| 4.5.1 Review Manager e GRADEpro | 41 |
| 5. RESULTADOS..... | 45 |
| 5.1 Caracterização geral dos estudos e intervenções | 45 |
| 5.2 Caracterização geral dos achados dos estudos | 56 |
| 5.2.1 Sessões de aconselhamento | 56 |
| 5.2.2 Programas multiestratégias | 57 |
| 5.2.3 Reforço comunitário | 59 |
| 5.3 Eficácia e viés das intervenções | 60 |
| 6. DISCUSSÃO..... | 63 |
| 6.1 Intervenções sumarizadas | 63 |
| 6.2 Desfechos e implicações clínicas | 65 |
| 6.2.1 Considerações gerais..... | 65 |
| 6.2.1 Aconselhamento..... | 66 |

| | |
|--|----|
| 6.2.2 Programas multiestratégias | 67 |
| 6.2.3 Reforço comunitário | 69 |
| REFERÊNCIAS | 72 |
| ANEXOS..... | 87 |
| APÊNDICES..... | 92 |

1. INTRODUÇÃO

As intervenções em saúde (IS) funcionam como iniciativas que oportunizam, de alguma maneira, melhorar as condições de saúde das pessoas, grupos ou das populações, expressando-se através de ações coletivas, operacionalizadas e executadas por organizações/instituições, ou ações individuais, efetivadas por cada indivíduo (NGUYEN *et al.*, 2020;). Nesta perspectiva, sejam educativas ou de cuidado em saúde, relacionam-se com as condições de saúde das pessoas, além de atrelar-se a outros fatores, como a diminuição dos custos econômicos com saúde e seguridade social (LAN *et al.*, 2017).

O desenvolvimento e aplicabilidade de IS, em particular as voltadas para os jovens, deve ter como prioridade um planejamento estratégico coeso e a identificação das necessidades de saúde, como também das prerrogativas da promoção da saúde (THABANE *et al.*, 2019). Este panorama evidencia ainda que a promoção da saúde beneficia continuamente a população, em especial os grupos mais vulneráveis, como por exemplo, os adolescentes em situação de rua (WEBER; LEE; MARTSOLF, 2017; NUTBEAM; MUSCAT, 2021).

Dessa forma, reconhece-se que a situação de rua é um fenômeno social, complexo, que ultrapassa a inexistência de moradia. Isto se traduz ao considerar que a definição de “sem-teto” vai além da falta de acomodação de forma permanente. Ademais, pode ainda compreender àqueles sujeitos que vivem na rua, mas, seja em abrigos ou casas de acolhimento, encontram local para dormir e/ou realizar algumas refeições (O'CARROLL; WAINWRIGHT, 2019; BECKER; FOLI, 2022). Posto isso, é importante compreender o contexto social em que vive a População em Situação de Rua (PSR) com necessidade de intervenções sociais para preveni-la (MABHALA; YOHANNES; GRIFFITH, 2017; ALPERT, 2021)

Tais preceitos, relacionam-se a uma gama de fatores que se centram na privação/déficit de: renda, emprego, acesso à educação, habilidades e treinamento, crime, saúde, ausência de habitação e serviços de apoio social, além do ambiente de vida (REEVE, 2017). Haja vista, esta população contempla indivíduos socialmente marginalizados das estruturas convencionais da sociedade e que sofrem com a falta de atendimento às necessidades humanas básicas, o que torna a sua sobrevivência frequentemente comprometida (LAN *et al.*, 2017).

As IS buscam modificar a realidade de saúde deste grupo populacional e apresentam-se como meio de tentar amenizar as iniquidades e promover hábitos de vida

mais saudáveis (MALTA *et al.*, 2018). Afere-se desse modo e considerando a saúde sexual, tema tão importante na adolescência, o escopo coberto pelas IS é amplo e deve compreender o cuidado, o aconselhamento e as atividades educativas (BRASIL, 2017a; THABANE *et al.*, 2019).

Para efeito de entendimento neste estudo, as IS podem ser classificadas em IS de caráter educativo e IS de cuidado em saúde, ambas, objeto de estudo desta revisão. As intervenções educativas (IE) em saúde são fundamentadas em práticas da educação em saúde, e para tanto, utilizam-se de metodologias e/ou estratégias pedagógicas para tornar os sujeitos protagonistas no cuidado de sua saúde e assim promovem hábitos preventivos e redução de danos/riscos (KATZ *et al.*, 2021). As intervenções de cuidado em saúde (ICS), por outro prisma, concentram-se no fornecimento de insumos/tecnologias no intento, também, de promover hábitos preventivos e redução de danos/riscos (WILLIANS *et al.*, 2017).

Desse modo catalogar estudos que desenvolvam/apliquem IS pode configurar importante instrumento para ratificar o impacto e relevância na vida e saúde destas pessoas, podendo ainda servir como meio de fomento/fortalecedor informacional para políticas públicas nacionais e globais.

Muitas das estratégias globais de prevenção da infecção pelo vírus da imunodeficiência humana (HIV) e das demais infecções sexualmente transmissíveis (IST), que compõe as IS, estão voltadas para o uso de preservativos, sejam elas articuladas ou não ao uso de outras tecnologias, como a profilaxia pós-exposição sexual (PEP) e pré-exposição sexual (PrEP) (GUTIERREZ *et al.*, 2020).

Além disso o uso do preservativo nas relações sexuais, considerando o âmbito da saúde sexual e da sexualidade dos adolescentes, alicerça-se na prevenção da transmissão das IST como estratégica para o controle da epidemia global de HIV/Aids e demais IST (NASCIMENTO; CAVALCANTI; ALCHIERI, 2017). Partindo disso, esta revisão sistemática (RS) tem potencial de avaliar as IS, visto que é importante conhecer suas características de implementação e os fatores que favorecem ou dificultam sua dinâmica, e o impacto na prevenção e redução de agravos na saúde sexual dos adolescentes em situação de rua, tornando-se válido e necessário.

Cabe ratificar que apesar do preservativo ser um dos métodos de prevenção mais difundidos e encorajados no mundo (MAITRE, 2022), nota-se uma diminuição e resistência significativa ao seu uso na última década. (PAIVA; CAITANA, 2020). Portanto a avaliação da implementação de IS que estimulem o uso do preservativo pode

ser uma estratégia oportuna e relevante para apreensão e compreensão das lacunas, barreiras e/ou potencialidades e assim contribuir com a readequação dos processos de trabalho, possibilitar/assegurar a adoção de comportamento sexual seguro, redução de agravos e melhoria das ações de cuidado.

2. OBJETIVOS

2.1 Geral

Analisar a literatura científica quanto a eficácia de intervenções em saúde para uso do preservativo por adolescentes em situação de rua.

2.2 Específicos

- ✓ Sumarizar as IS educativas e de cuidado em saúde voltadas a adolescentes em situação de rua;
- ✓ Verificar a eficácia das intervenções educativas e de cuidado em saúde quanto ao uso do preservativo em adolescentes em situação de rua;
- ✓ Sintetizar os achados dos estudos quanto ao uso do preservativo em adolescentes em situação de rua.

3. REFERENCIAL TEÓRICO

3.1 Caracterização das intervenções de saúde para uso do preservativo

As IS funcionam como condicionantes e determinantes sociais da saúde, dirigidas a impactar favoravelmente a qualidade de vida. Por isso, caracterizam-se fundamentalmente por uma composição intersetorial e, intra-setorialmente, pelas ações de ampliação da consciência sanitária – direitos e deveres da cidadania, educação para a saúde, estilos de vida e aspectos comportamentais (WHO, 1986; KESSLER *et al.*, 2018).

Tendo em vista este conceito, as IS visam divulgar, sensibilizar e mobilizar através de ações voltadas essencialmente na alimentação saudável; prática corporal e atividade física; saúde sexual e planejamento reprodutivo, prevenção e controle do tabagismo; redução da morbimortalidade em decorrência do uso abusivo do álcool e de outras drogas; redução da morbimortalidade por acidentes de trânsito; prevenção da violência e estímulo à cultura da paz e promoção do desenvolvimento sustentável (TANGCHAROENSATHIEN, 2017).

Um forte instrumento utilizado nas ações e políticas públicas de saúde sexual envolve o uso do preservativo pelos adolescentes. Entretanto verifica-se que a não adesão ao preservativo pelos adolescentes tem sido relacionada à baixa credibilidade depositada no método ou sua banalização, crença na invulnerabilidade às infecções, menores sensações prazerosas, situações de marginalização social, natureza contestadora, não concordância do parceiro, dentre outros, o que contribui para maiores incidências de IST nessa população (TAQUETE *et al.*, 2017; BRASIL *et al.*, 2017b; FELISBINO-MENDES *et al.*, 2018; ZAPE; ALVES; DELL’AGLIO *et al.*, 2019).

Grande parte das estratégias de intervenção do mundo partem da ideia de que o controle e prevenção das IST/HIV devem angariar-se sobre uso corrente e adequado do preservativo como medida de proteção. Todavia, é comum a rejeição do seu uso em quaisquer dos gêneros (BRASIL *et al.*, 2017b). No último século, ao mesmo tempo em que os contraceptivos atingiram popularidade, seguidos por uma campanha global de planejamento familiar de grande dimensão, a prática do sexo desprotegido e sua comunicação com as infecções adquiridas sexualmente continua alarmante, caracterizando as epidemias globais de HIV e outras IST não superadas (NASCIMENTO; CAVALCANTI; ALCHIERI, 2017).

O preservativo é considerado o único método que proporciona dupla proteção, contra as IST, incluindo HIV/Aids, e contra gravidez (BRASIL, 2017a). Por outro lado,

estudos também demonstram a descrença na possibilidade de engravidar sendo muito jovem, e principalmente na primeira relação sexual, incidindo ainda mais sobre a não adesão ao método (TAQUETE *et al.*, 2017; FELISBINO-MENDES *et al.*, 2018; ARAÚJO *et al.*, 2019).

As IS buscam atender as demandas de saúde da população com vistas à melhoria da qualidade de vida, o que é objeto de preocupação em todos os sistemas de saúde, considerando o alto custo das tecnologias em saúde e a escassez de recursos públicos. Nesse cenário de atenção, ações de promoção e prevenção de doenças no âmbito da saúde sexual, são consideradas eixos prioritários de prevenção (BRASIL, 2017b; MAITRE, 2022).

É necessário realizar, nesse seguimento, uma abordagem educacional e clínica que possibilite o exercício da aprendizagem transformadora, em que indivíduos e comunidades possam construir habilidades e atitudes pautadas no senso crítico, percepções sobre os benefícios da saúde e sua promoção no viver cotidiano, no seu desenvolvimento pessoal e coletivo (SÁ *et al.*, 2020).

Atentar que a promoção da saúde com adolescentes ocorre por meio de procedimentos preventivos e orientação de comportamentos saudáveis é primordial, sendo indispensável associá-los ao contexto socioeconômico-cultural, a considerar os que vivem em situação de rua. Dessa forma, tais fatores estão associados a iniquidades e vulnerabilidades, uma vez que a promoção da saúde com adolescentes ainda se apresenta de modo incipiente (SCHAEFER *et al.*, 2018).

Logo, as IS focadas na maior adesão e uso do preservativo pelos adolescentes podem ter enfoque educacional ou práticas que envolvam cuidado clínico/manejo assistencial, cada uma com suas características e abordagens específicas.

3.2 Intervenções Educativas – IE

A educação em saúde (ES), pela sua magnitude, deve ser entendida como uma importante vertente à prevenção, e que na prática deve estar preocupada com a melhoria das condições de vida e de saúde das populações (PUEYO-GARRIGUES *et al.*, 2019). Para tanto, nesta revisão as IE serão caracterizadas como intervenções que se utilizam da ES na construção e aplicação das intervenções.

Intervenções com enfoque na ES podem ser definidas como um conjunto de práticas pedagógicas, participativas, que engloba saberes que compreendem os diversos

campos de atuação e que empoderam as pessoas e as comunidades a desenvolverem suas capacidades. Para tanto as práticas de educação em saúde contemporâneas são dialógicas, abordam temas que estão relacionados com o cotidiano das pessoas, como lazer, alimentação saudável, conhecimento popular, podendo ser coletivas ou individuais (BIRCH; AULD, 2019).

Para alcançar um nível adequado de saúde, as pessoas precisam saber identificar e satisfazer suas necessidades básicas. Devem ser capazes de adotar mudanças de comportamentos, práticas e atitudes, além de dispor dos meios necessários à operacionalização dessas mudanças. Assim, a ES significa contribuir para que as pessoas adquiram autonomia para identificar e utilizar as formas e os meios para preservar e melhorar a sua vida (HERVAL *et al.*, 2019)

Considerando que a ES está relacionada à aprendizagem, desenhada para alcançar a saúde, torna-se necessário que esta seja voltada a atender a população de acordo com sua realidade. Isto porque a educação em saúde deve provocar reflexões nas pessoas, criando oportunidade para pensar e repensar a sua cultura, e ele próprio transformar a sua realidade (RAMOS *et al.*, 2018).

Nesse seguimento, o alcance da ES, pode atingir significativamente os adolescentes em situação de rua, observando-se a necessidade da utilização de estratégias de ensino-aprendizagem que oportunizem maior autonomia dos sujeitos, visto que as relações verticalizadas, nas quais o facilitador/profissional é o único detentor do conhecimento são ultrapassadas e não consideram o compartilhamento de ideias e experiências pessoais, além de não serem eficazes (FITZPATRICK, 2019).

Atrelado a isso é importante se considerar que a adolescência, rito de passagem da infância ao mundo adulto, é um período crítico para o desenvolvimento de hábitos e costumes, o que pode incitar, pela curiosidade muito presente nessa fase, o uso de álcool e outras drogas, envolvimento em situações de violências e relações sexuais desprotegidas, sendo, portanto, considerada uma fase de maior vulnerabilidade e riscos. Dessa forma, é necessário que os adolescentes tenham acesso a informações de qualidade sobre aspectos relacionados à prevenção de doenças e promoção da saúde (LEONARDI *et al.*, 2019).

Considerando o exposto e no intento de ilustrar possíveis IE que possam ser identificadas neste estudo, o quadro 1 apresenta algumas estratégias/opções metodológicas que favorecem a autonomia e participação nas IE, seguidas de seus respectivos conceitos.

Quadro 1: Descrição das intervenções educativas quanto a seus conceitos.

| INTERVENÇÃO EDUCATIVA | CONCEITO |
|-------------------------|---|
| Aconselhamento | Prática educativa oferecida por profissionais de saúde com o objetivo empoderar as pessoas sobre seu processo de saúde, dentro do respeito à autonomia e valorização de seu potencial, propiciando uma mudança de comportamento e melhoria na qualidade de vida (FLORES <i>et al.</i> , 2018). |
| Grupo focal | Consiste no uso de entrevista onde ocorre uma exposição oral específica e espontânea dos envolvidos. Esta técnica fomenta interações de um grupo sobre um tema proposto, juntamente com os debates suscitados entre os participantes (SCHVINGEL; GIONGO; VIER MUNHOZ, 2017). |
| Roda de conversa | Possibilidade metodológica para uma comunicação dinâmica e produtiva entre profissional/professor e pacientes/alunos. Essa técnica apresenta-se como um rico instrumento para ser utilizado como prática metodológica de aproximação entre os sujeitos no cotidiano pedagógico/serviços de saúde (MOTISUKI DIAS <i>et al.</i> , 2018). |
| Oficinas | Metodologia de trabalho que prevê a formação coletiva. Ela prevê momentos de interação e troca de saberes a partir da uma horizontalidade na construção do saber inacabado. Sua dinâmica baseia-se na dialética/dialogicidade envolvendo a relação educador e educando (FERNANDES; SPAGNUOLO, 2021). |
| Álbum seriado | Consiste em uma coleção de folhas (cartazes) organizadas que podem conter mapas, gráficos, desenhos, textos e outros. Seu uso é extenso na área da educação em saúde e dentre as suas vantagens destacamos: direcionar a sequência da exposição, possibilitar a imediata retomada de qualquer folha já apresentada, possibilitar a utilização de materiais diversos na sua confecção, |

| | |
|---|---|
| | como fotografias e desenhos, e assinalar os pontos essenciais de cada tópico apresentado (SARAIVA; MEDEIROS; ARAUJO, 2018). |
| Exposição dialogada | Ações que utilizam material educativo utilizam-se da aplicação concomitante da orientação verbal/visual e da escrita o que torna o método mais efetivo, facilitando a compreensão dos sujeitos e promove melhoria na adaptação ao contexto sociocultural no qual estão inseridos (MOURA <i>et al.</i> , 2017). |
| Tecnologias digitais da informação e comunicação | Integram-se em bases tecnológicas que possibilitam a partir de equipamentos, programas e mídias, a associação de diversos ambientes e pessoas numa rede, facilitando a comunicação entre seus integrantes, ampliando as ações e possibilidades já garantidas pelos meios tecnológicos (DORES <i>et al.</i> , 2020). |

Fonte: Autor. Fortaleza, CE, Brasil, 2022.

Baseado nas prerrogativas e conceitos listados, a inserção da ES nas intervenções em saúde para o uso do preservativo por adolescentes é fundamental, considerando que esta tem um papel fundamental na nossa sociedade levando informação e conhecimento à população sobre como se cuidar e garantir uma melhor saúde (em seu significado mais amplo), principalmente de maneira preventiva. Portanto, é valido frisar que o enfoque em informação e prevenção é uma valiosa ferramenta para evitar doenças, possibilitando usufruir de uma vida mais saudável.

3.3 Intervenções de Cuidado em Saúde – ICS

As ICS, considerando o modo como são organizadas, são as ações de atenção à saúde, envolvendo os aspectos tecnológicos e de assistência direta, ou seja, é uma forma de organização e articulação entre os diversos recursos físicos, tecnológicos e humanos disponíveis para enfrentar e resolver os problemas de saúde. O uso das tecnologias configura-se como um pilar no emprego destes tipos de IS com forte enfoque curativo, na disponibilização de insumos e reabilitação/tratamento (FLANAGAN; DAMERY; COMBES, 2017; FISCHER *et al.*, 2021).

As ICS, são as que ofertam insumos necessários a redução de danos à saúde. Neste sentido, considerando o estímulo ao uso de preservativos para práticas de sexo

seguro, a oferta/distribuição da camisinha tanto masculina quanto feminina e de géis lubrificantes são consideradas intervenções de cuidado em saúde (BRASIL, 2017a).

A promoção do uso de preservativo articula-se, em conceitos operativos da prevenção da aids e outras IST, à superação da ideia de grupos de risco por uma concepção comportamentalista da prevenção, articulada em termos de comportamentos de risco *versus* práticas seguras (MOREIRA; DUMITH; PALUDO, 2018). Cabe ressaltar que as estratégias de prevenção da infecção pelo HIV e outras IST ainda são amplamente baseadas no uso de preservativos, apesar da atual disponibilidade de outras tecnologias (GUTIERREZ *et al.*, 2019).

Este cenário mostra a importância da adesão ao uso do preservativo, considerando as experiências com programas/políticas públicas no que concerne sobre a educação sexual e mudanças de comportamento, com a utilização concomitante de outras tecnologias com o preservativo, como a PrEP (Profilaxia Pré-Exposição) e PEP (Profilaxia Pós-Exposição) – com a distribuição dos fármacos e de preservativos juntos, com orientações sobre a prevenção combinada as IST -, a testagem rápida - como forma de diagnóstico precoce, com distribuição de preservativos/ géis lubrificantes e também como parte da prevenção combinada - e vacinação para Hepatites A e B, HPV com orientações sobre prevenção a IST e distribuição de preservativos. Tais estratégias visam maximizar a prevenção e possibilitar maior adesão ao preservativo dentro do contexto de sexo seguro e prevenção combinada (BRASIL, 2017a; CALAIS; PERUCCHI, 2017; ZUCCHI *et al.*, 2018).

Tais estratégias trazem a necessidade de refletir sobre a importância de políticas públicas voltadas para a conscientização e o acesso ao preservativo entre adolescentes e jovens no início da vida sexual (GUTIERREZ *et al.*, 2019). Atrelado a isto, é notório que à medida que a eficácia (efeitos em condições ideais) e a efetividade (efeitos em condições da vida real) dos preservativos na redução da transmissão do HIV se tornaram aparentes durante a década de 1980, sendo seu uso promovido ativamente, o que levou a um aumento constante na aceitação do preservativo (SOUZA *et al.*, 2019).

Considerando o cenário de vulnerabilidade social e econômica que vivem os adolescentes em situação de rua, a disponibilidade e promoção ao uso de preservativos distribuídos de forma gratuita pode aumentar a aceitação, e, portanto, diminuir a transmissão de IST e evitar gestações não planejadas.

Assim, as ICS fornecem insumos e meios consistentes para o uso do preservativo pelos adolescentes em situação de rua, no intento de garantir práticas sexuais seguras,

conceito ampliado ainda pela possibilidade de prevenção combinada ao se utilizar outras tecnologias de forma adjunta ao preservativo.

3.4 Caracterização da população adolescente em situação de rua

A população em situação de rua é considerada um grupo populacional heterogêneo que possui em comum a pobreza extrema, os vínculos familiares interrompidos ou fragilizados e a inexistência de moradia convencional regular, e que utiliza áreas públicas como espaço de moradia e de sustento, de forma temporária ou permanente, bem como as unidades de acolhimento para pernoite temporário ou como moradia provisória (BRASIL, 2014; BECKER; FOLI, 2022).

Estima-se que 2% da população global não tenha moradia, o que corresponde a aproximadamente 150 milhões de pessoas (ONU, 2022). Destes, a nível de Brasil, com estimativa realizada pelo Instituto de Pesquisa Econômica Aplicada (IPEA) em 2020, existem cerca de 222 mil pessoas vivendo em situação de rua, com um crescimento de 140% nos últimos oito anos (IPEA). Os dados do último censo do Instituto Brasileiro de Geografia e Estatística (IBGE), confirmam que 17,9% da população brasileira é composta por pessoas entre 10-19 anos de idade – faixa etária que, cumpre lembrar, corresponde à adolescência, segundo a definição da Organização Mundial de Saúde (OMS). Desse número, pela ultima estimativa realizada pela Organização não Governamental (ONG) Visão Mundial, há cerca de 70 mil crianças e adolescentes em situação de rua em todo território brasileiro.

Os adolescentes, sujeitos de direitos, constituem um grupo populacional que exige novos modos de produzir saúde, inclusive a saúde sexual e a saúde reprodutiva. Atrelado a isto, considera-se ainda que a adolescência, é marcada por um complexo processo de crescimento e desenvolvimento quando a pessoa vivencia inúmeras transformações, que resultam em mudanças de ordem física, cognitiva e psicossocial (SILVA *et al.*, 2017; OLIVEIRA *et al.*, 2017). Essa fase, os classifica como um grupo de grande vulnerabilidade no contexto da rua, principalmente pelos impactos psicológicos que sofrem frente às desigualdades e injustiças sociais, com destaque a violência (SILVA *et al.*, 2020; BARONE *et al.*, 2019).

Cabe ressaltar ainda que seu ciclo de vida particularmente saudável evidencia que os agravos em saúde decorrem, em grande medida, de modos de fazer “andar a vida”, de hábitos e comportamentos, que, em determinadas conjunturas, os vulnerabilizam. As

vulnerabilidades produzidas pelo contexto social e as desigualdades resultantes dos processos históricos de exclusão e de discriminação determinam os direitos e as oportunidades de adolescentes e jovens (BRASIL, 2018).

A Organização Nacional das Nações Unidas (ONU) e a OMS sugerem que sejam priorizados o cuidado a grupos vulneráveis estruturado ao exercício dos direitos humanos e da cidadania. Dessa maneira, os adolescentes em situação de rua, por sua vez, estando constantemente sujeitos à violação de seus direitos, devido ao enfraquecimento do vínculo familiar e da comunidade, da proteção inadequada do estado, a ausência da escola, o trabalho infantil, o envolvimento com o tráfico de drogas, dentre outras, carecem de políticas públicas direcionadas no intento de minimizar danos (RIZZINI; COUTO, 2019).

Ressalta-se que na atenção à adolescentes deve-se garantir cuidado como escuta ativa e acolhimento das demandas de saúde, procurando dar resposta às necessidades por meio da prevenção de agravos, promoção da saúde e recuperação de doenças (BRASIL, 2018). Contudo, demandas de adolescentes, entendidas como expressão de necessidades de cuidado, são comumente difíceis de lidar segundo os padrões que se estabelecem nas instituições, sobretudo as que dizem respeito à sexualidade. Sexualidade neste sentido, envolve comportamento e processos, incluindo os aspectos biopsicossociais, fisiológicos, culturais, políticos, espirituais e religiosos relacionados ao sexo e ao comportamento sexual (BRASIL, 2017; BARONE *et al.*, 2019).

Adolescentes necessitam ser orientados e estimulados, por meio de programas específicos. Para isso, é importante que sociedade e profissionais estejam capacitados para aconselhamento sexual e para abordar a sexualidade (BRASIL *et al.*, 2018). Estes preceitos devem então estar pautados na busca de uma revisão de seus valores individuais para que não se perpetuem mitos, crenças e preconceitos e que a educação sexual formal não seja instrumento de repressão, mas uma contribuição positiva para o desenvolvimento integral do adolescente (JORGE *et al.*, 2017).

3.5 Saúde sexual e adolescência

Saúde sexual é a habilidade de mulheres e homens de desfrutar e expressar sua sexualidade, sem risco de IST, gestações não desejadas, coerção, violência e discriminação, propiciando a vivência da sexualidade humana de forma positiva,

informada, agradável e segura, baseada na autoestima e no respeito mútuo nas relações sexuais (BRASIL, 2017a).

A sexualidade é um campo de saber e de práticas que remete a noções ampliadas de saúde e aos direitos sexuais e reprodutivos, sendo a definição de saúde sexual: a habilidade de expressar e viver a sexualidade, sem riscos de doenças, discriminação ou violência, inserida no contexto das ações de saúde reprodutiva (JORGE *et al.*, 2017).

Este conceito transpassa a dimensão da personalidade, que é moldada por esses aspectos, estando muitas vezes reprimida e aprisionada no campo do desejo. Ela remete a um prazer sensual, sedução, excitação, erotismo, orgasmo, conhecimento do próprio corpo e do corpo do outro (SILVA *et al.*, 2020). O processo de descoberta e vivencia da sexualidade vem acontecendo de forma rápida, com isso faz-se necessário que adolescentes encontrem pessoas capazes de lhes apoiar, pois a socialização é a maneira pelo qual o ser humano interioriza valores, crenças atitudes e normas de conduta que são próprias do seu grupo social, ou da sociedade, interferindo na atitude do adolescente em relação à sexualidade (FERREIRA *et al.*, 2020).

Na adolescência, a sexualidade se apresenta, simultaneamente, como mudança física, psicológica e social. Por vezes os adolescentes não encontram espaço para dialogar sobre sexualidade. Entretanto, estes procuram meios, como televisão, amigos e revistas, acarretando, na maioria das vezes, informações insuficientes, o que os tornam vulneráveis à gravidez não planejada e IST. Essa vulnerabilidade também está associada ao início da vida sexual precoce ou a não utilização de métodos contraceptivos, realidade que os adolescentes que vivem em situação de rua, experimentam de forma potencializada (NUNES *et al.*, 2017).

A atenção à saúde sexual de adolescentes tem enfrentado alguns entraves e desafios. Considera-se que por um lado têm-se observado esforços dos governantes e organizações para promover a saúde sexual e reprodutiva da população jovem, por outro, grandes desafios permanecem (CABRAL; BRANDÃO, 2020). A exemplo, observa-se em alguns grupos mais vulneráveis, aumento da taxa de fertilidade nessa população, principalmente em menores de 15 anos que vivem nos países da América Latina (ROSELINE; COSTA; SUTILE, 2020). Também se observa que a população jovem tem uma elevada carga de doenças relacionadas à gravidez não planejada e aos nascimentos, sem contar as IST, incluindo o HIV/aids, morte materna e aborto (TAQUETE *et al.*, 2017; BRASIL *et al.*, 2017b; FELISBINO-MENDES *et al.*, 2018).

É oportuno realizar IE e promover através destas uma reflexão sobre a sexualidade

e como exerce-la, orientando os adolescentes quanto a seus direitos para que possam fazer escolhas saudáveis de acordo com seus projetos de vida e decidir, em que momento e se querem ou não, iniciar ou ter relações sexuais (LOUVEIRA FIGUEIREDO, 2020).

No cenário nacional, considerando que as políticas públicas nacionais direcionadas a saúde da população em situação de rua, integradas ao Sistema Único de Saúde (SUS) estão integradas na Atenção Básica, as condutas envolvendo a ES aos adolescentes devem seguir uma lógica construídas nos princípios que estes programas/planos de saúde se norteiam (BRASIL, 2018).

A produção científica evidencia que os comportamentos sexuais dos adolescentes em situação de rua e sua exposição a IST como a infecção por HIV são acentuados. Brown e colaboradores (2021) em revisão sistemática constataram que adolescentes em situação de rua são mais suscetíveis a exposição ao HIV, em decorrência de comportamentos problemáticos, e que, os jovens heterossexuais em similar situação de rua formam redes sociais com membros de influência mais protetiva (pró-sociais).

Outro estudo sobre adolescentes e seus fatores de risco e de proteção em relação às IST/HIV/Aids mostrou desconhecimento dos adolescentes relacionado a prevenção e que são considerados um público que se encontra exposto a fatores de risco contínuos para IST (MESQUITA *et al.*, 2017).

Atrelado a estas evidências, outros estudos corroboram na afirmativa que esta população, pelas características que têm, está mais exposta a riscos decorrentes de comportamentos sexuais e precisam de apoio/atenção relacionado ao início da vida sexual, ao uso do preservativo e acesso à informação sobre IST/HIV/Aids e à prevenção da gravidez (CAMPOS *et al.*, 2017; HEREDIA-MARTÍNEZ; ARTMANN; NASCIMENTO, 2020).

4. MÉTODO

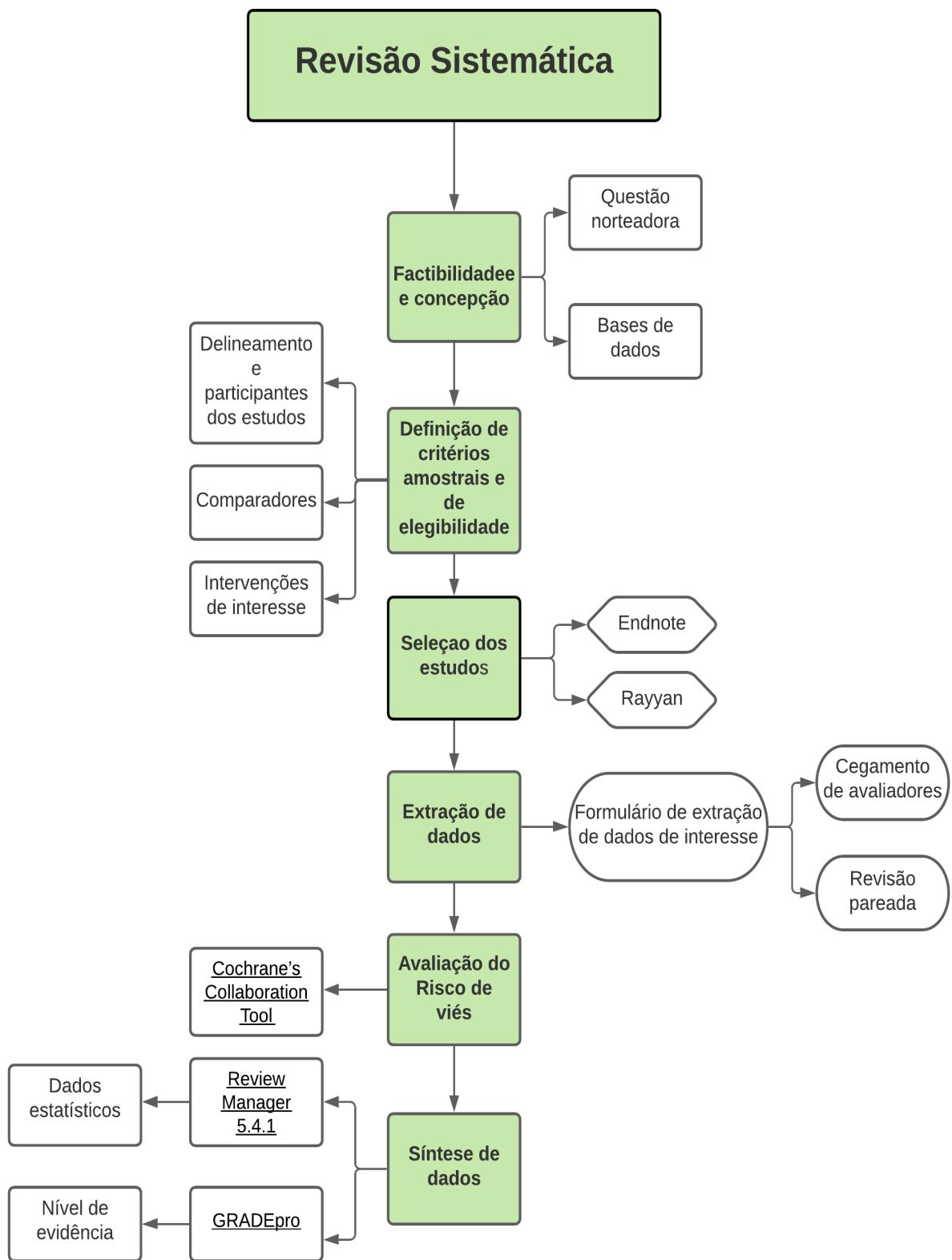
Trata-se de uma revisão sistemática (RS) baseada pelos *Guidelines Cochrane* (<https://training.cochrane.org/handbook>), sendo um tipo de estudo secundário, que busca reunir estudos semelhantes, avaliando-os criticamente em sua metodologia e reunindo-os numa análise estatística, a metanálise, quando possível. Por sintetizar estudos primários semelhantes e de boa qualidade é considerada o melhor nível de evidência para tomadas de decisões (HIGGINS *et al.*, 2022).

A RS *Cochrane* inicia-se com a elaboração da questão de pesquisa, e de um projeto de revisão (Protocolo). A seguir é realizada uma ampla busca da literatura com o objetivo de se identificar o maior número possível de estudos relacionados à questão. Uma vez selecionados, aplicam-se critérios para avaliação da qualidade metodológica conforme o delineamento do estudo original (HIGGINS *et al.*, 2022).

A RS visa ainda minimizar o preconceito usando métodos explícitos e sistemáticos documentados com antecedência com um protocolo (CHANDLER *et al.*, 2021). Esta revisão teve seu protocolo registrado e publicado na plataforma PROSPERO (Em português - Registro Prospectivo Internacional de Revisões Sistemáticas) sob número CRD42021266572 (ANEXO B) e seguiu as diretrizes de redação e processo de seleção dos estudo pelo *guideline* PRISMA, recomendado pela rede EQUATOR (<https://www.equator-network.org/>) (PAGE *et al.*, 2021).

Este estudo seguirá etapas delimitadas (Figura 1), com itinerário metodológico baseado nas etapas preconizadas por Higgns *et al* (2022), como segue:

Figura 1: Fluxograma com itinerário metodológico aplicado na RS.



Fonte: Autor, Fortaleza – Ceará, Brasil, 2022.

4.1 Factibilidade e concepção

4.1.1 Questão norteadora

Como questão de pesquisa adotou-se: Intervenções educativas e/ou de cuidados em saúde são eficazes para promover o uso do preservativo por adolescentes em situação de rua? O quadro abaixo ratifica a estrutura (acrônimo PICOS) utilizada na formulação da questão norteadora desta revisão.

Quadro 2: Descrição dos termos e assuntos de interesse utilizados na revisão.

| Estratégia PICOS | |
|---------------------------|---|
| P (População) | Adolescentes em situação de rua |
| I (Intervenção) | Intervenções educativas e/ou intervenções de cuidado em saúde para uso do preservativo |
| C (Comparador) | Nenhuma intervenção e/ou intervenção de saúde sexual de outra natureza (ex: Triagem de IST, Disponibilização de kits, Campanhas de vacinação) |
| O (Desfecho) | Uso do preservativo |
| S (Tipo de estudo) | Ensaios clínicos randomizados e não randomizados, estudos controlados antes e depois, coortes e caso-controle |

Fonte: Autor. Fortaleza, CE. Brasil, 2022.

4.1.2 Bases de dados

As bases de dados consultadas foram: *Medical Literature Analysis and Retrieval System Online* (Medline), *Cochrane Central Register of Controlled Trials* (CENTRAL), PsycINFO - American Psychological Association, SciVerse Scopus, Excerpta Medica dataBASE (EMBASE), *Web of Science*, *Cumulative Index to Nursing and Allied Health* (CINAHL), Literatura Latino-Americana e do Caribe em Ciências da Saúde (LILACS) e o Banco de Dados em Enfermagem – Bibliografia Brasileira (BDENF).

Para tanto foi utilizada a linguagem controlada (LC) específica de cada base, associada a linguagem natural (LN) no intuito de ampliar a sensibilidade e alcance. Para efeito de entendimento, foi utilizado (LC) e (LN) para sinalizar quais os termos na estratégia, mas os mesmos não serão usados no momento de aplicação nas bases. A operacionalização das estratégias (Quadro 3) segue descrita abaixo:

Quadro 3: Estratégias de busca, conforme as bases de dados e os vocabulários controlados, utilizadas na RS.

| CODIFI CAÇÃO | BASE DE DADOS | ESTRÁTEGIA |
|---------------------|----------------------|--|
| DeCS | LILLACS, BDENF. | (“Homeless youth”(LN) OR “Homeless Persons”(LC)) AND (Adolescent (LC) OR Adolescents(LN)) AND (“condom distribution”(LN) OR “Health Education ”(LC) OR telemedicine(LC) OR “Sex Counseling”(LC) OR “conversation wheel”(LN) OR “Sex Education”(LC) OR “peer sex education”(LN) OR workshops (LN) OR “condom use”(LN) OR Condoms (LC) OR condom(LN) OR “male condom”(LN) OR “female condom”(LC)) AND (“Pregnancy in Adolescence ”(LC) OR “Sexually Transmitted Diseases “(LC) OR “sexually transmitted infections”(LN) OR HIV(LC) OR “teenage pregnancy”(LN) OR Syphilis (LC) OR Hepatitis (LC) OR “Hepatitis B”(LC) OR “Hepatitis C”(LC)) |
| MeSH | Medline, Scopus*. | (“Homeless Youth”(LC) OR “Youth, Homeless”(LC) OR “Youths, Homeless”(LC) OR “Youth, Homeless”(LC) OR “Homeless Youths”(LC)) AND (“Sexual education”(LC) OR “condom distribution”(LC) OR “condom distribution program”(LC) OR "Condoms, Female supply and distribution"(LN) OR “Condoms supply and distribution”(LN) OR “condom use”(LC) OR condom(LC) OR “male condoms” (LC) OR “internal condoms”(LC) OR “Condoms, Female” (LC) OR "Condoms trends"(LN) OR “Condoms utilization” (LN) OR “Condoms, Female trends”(LN) OR “Condoms, Female utilization”(LN) OR “Counseling” (LC) OR “Sex Counseling”(LC) OR “Health Education”(LC) OR Telemedicine(LC) OR mHealth(LC) OR “Mobile Health” (LC) OR “informative material”(LC)) AND (“Pregnancy in Adolescence”(LC) OR “Adolescent Pregnancies”(LN) OR “Adolescent Pregnancy”(LN) OR “Teen Pregnancy”(LN) OR “Teen Pregnancies”(LN) OR “Sexually Transmitted Diseases” (LC) OR “Sexually Transmitted Infections”(LN) OR “Sexually Transmitted Infection”(LN) OR “Sexually Transmitted Disease”(LN) OR Syphilis(LC) OR “HIV Infections”(LC) OR “HIV Infection”(LN) OR HIV(LN) OR Hepatitis(LC) OR “Hepatitis B”(LC) OR “Hepatitis C” (LC)) |
| Emtree thesauros | Scopus*, EMBASE | (“homeless youth”(LC) OR “homeless”(LC) OR “homeless persons”(LC)) AND (adolescent(LN) OR teenage(LN)) AND (“Sexual education”(LC) OR “condom distribution”(LC) OR “Condom distribution program”(LC) OR Counseling(LC) OR “Sex Counseling”(LC) OR “Prescriptive Counseling”(LC) OR “health Counseling”(LC) OR |

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| | | Telemedicine(LC) OR mHealth(LC) OR “Mobile Health”(LC) OR “informative material”(LC) OR “condom use”(LC) OR “Condoms utilization”(LN) AND (“sexually transmitted disease”(LC) OR “Sexually Transmitted Infections”(LN) OR “adolescent pregnancy”(LC) OR “Adolescent Pregnancies”(LN) OR “Pregnancy in Adolescence”(LN) OR “Teen Pregnancies”(LN) OR “Human immunodeficiency virus”(LC) OR HIV(LN) OR Syphilis(LC) OR Hepatitis(LC) OR “Hepatitis B”(LC) OR “Hepatitis C”(LC)) |
| APA tesauros | PsycINFO | (Homeless(LC)) AND (“Homeless Youth”(LN) OR adolescent(LN) OR teenage(LN)) AND (“Sexual Health”(LC) OR “Safe Sex”(LC) OR Condom(LC) OR “condom distribution”(LN) OR “condom distribution program”(LN) OR “Health Education”(LC) OR Counseling(LC) OR “Health Information Technology”(LC) OR MHealth(LC) OR “condom use”(LN) OR condom(LN) OR “male condoms”(LN) OR “internal condoms”(LN) OR “Condoms, Female”(LN) OR “Condoms trends”(LN) OR “Condoms utilization”(LN) OR “Condoms, Female trends”(LN) OR “Condoms, Female utilization”(LN)) AND (“Adolescent Pregnancy”(LC) OR “Teenage Pregnancy”(LN) OR “Adolescent Pregnancies”(LN) OR “Teen Pregnancy”(LN) OR “Teen Pregnancies”(LN) OR “Sexually Transmitted Diseases”(LC) OR “Sexually Transmitted Infections”(LN) OR “Hepatitis B”(LN) OR “Hepatitis C”(LN) OR Syphilis(LC) OR HIV(LC)) |
| CINAHL Sub ject Headings | CINAHL | (Homelessness (LC) OR “Homeless Persons”(LC) Homeless(LN)) AND (Adolescence(LC) OR Adolescent (LN) OR Adolescents(LN)) AND (Condom(LN) OR Condoms(LC) OR “condom distribution” OR “Female Condoms”(LC) OR “Male Condoms”(LN) OR “Condom use”(LN) OR Counseling(LC) OR “Sexual Counseling”(LC) OR “Peer Counseling”(LC) OR “condom distribution”(LN) OR Telemedicine(LC) OR Telehealth(LC) OR mHealth(LN) OR “Health Education”(LC)) AND (“Pregnancy in Adolescence” (LC) OR “Adolescent Pregnancy”(LN) OR “Teen Pregnancy”(LN) OR Sexually Transmitted Diseases(LC) OR “Sexually Transmitted Infections”(LN) OR “Human Immunodeficiency Virus”(LC) OR HIV(LN) OR “HIV Infections” (LC) OR “HIV Education”(LC) OR Hepatitis(LC) OR “Hepatitis B”(LC) OR “Hepatitis C”(LC) OR Syphilis(LC)) |
| Palavras- chave | Web of Science, Cochrane Central Register of Controlled | (Homeless OR “Homeless persons” OR “Homeless Youth” OR “Homeless adolescent” OR “homeless teenage”) AND (“Sexual education” OR “condom distribution” OR “condom distribution program” OR “Condoms supply and distribution” OR “condom use” OR “condom” OR “male condoms” OR “internal condoms” OR “Female condoms” OR “Condoms trends” OR “Condoms utilization” OR “Counseling” OR |

| | | |
|--|----------------------|---|
| | Trials (CENTRAL). | "Sex Counseling" OR "Health Education" OR "Telemedicine" OR "mHealth" OR "Mobile Health") AND ("Pregnancy in Adolescence" OR "Adolescent Pregnancies" OR "Adolescent Pregnancy" OR "Teen Pregnancy" OR "Teen Pregnancies" OR "Sexually Transmitted Diseases" OR "Sexually Transmitted Infections" OR "Sexually Transmitted Infection" OR "Sexually Transmitted Disease" OR Syphilis OR "HIV Infections" OR "HIV Infection" OR HIV OR "Hepatitis Infection" OR "Hepatitis B" OR "Hepatitis C") |
|--|----------------------|---|

*A base de dados Scopus utiliza linguagem Mesh e Emtree thesauros

*(LC) -Linguagem controlada

*(LN) – Linguagem natural

Fonte: Autor. Fortaleza, CE, Brasil, 2022.

4.2 Definição de critérios amostrais e de elegibilidade

4.2.1 Delineamento e participantes dos estudos

4.2.1.1Quanto ao tipo de estudo

Inclusão: Ensaios clínicos randomizados (ECR), com randomização em nível individual ou de grupo. Ensaios clínicos controlados não randomizados (Não-ECR são estudos que alocaram participantes a intervenções por alternância entre grupos, pelo uso de datas de nascimento ou dias da semana, ou por outros métodos não aleatórios), com alocação em nível individual ou de grupo. Estudos controlados antes e depois com um mínimo de duas intervenções e dois locais de controle; tempo comparável dos períodos de estudo para os grupos de controle e intervenção; e comparabilidade dos grupos de intervenção e controle nas características principais. Estudos observacionais de coorte (com comparadores). Estudos de caso-controle.

Exclusão: Estudos sem comparadores, protocolos - pilotos.

4.2.1.2 Quanto a amostra

Inclusão: adolescentes (idades de 10 a 19) – (OMS, 2021) em situação de rua.

Exclusão: estudos em que os participantes são "jovens", com populações de adolescentes e adultos (por exemplo, "idades de 13 a 24"), exceto nos que os resultados dos adolescentes sejam estratificados e relatados separadamente daqueles da população geral.

4.2.2 Comparadores

Inclusão: Intervenção para a prevenção de HIV/IST para uso do preservativo OU nenhum comparador.

Exclusão: Intervenções para promoção de saúde sexual de outra natureza (PREP, PEP, Testagem rápida, uso anticoncepcionais, DIU, diafragma) OU nenhum comparador.

4.2.1 Intervenções de interesse

Inclusão: Intervenções educativas e Intervenções de cuidado em saúde que visem o uso do preservativo na redução do risco de infecção pelo HIV e de outras IST entre adolescentes em situação de rua (fugitivos de casa, moradores de abrigos/albergues serão incluídos também) que relatam um resultado primário.

Exclusão: Intervenções que contemplam o contexto de situação de rua; estudos que tratem da temática e população, mas que os resultados não são estratificados por faixas etárias (quando houver a inclusão de jovens 20 -24 anos) e intervenções sem comparadores.

4.3 Seleção dos estudos

4.3.1 Rayyan / Endnote

As referências foram gerenciadas com o uso *softwares* Rayyan /ENDNOTEweb. O Rayyan é um aplicativo da web gratuito, totalmente financiado pela *Qatar Foundation*, uma organização sem fins lucrativos do Qatar, utilizado primariamente para auxílio em pesquisas do tipo revisão sistemática e metanálise.

O ENDNOTEweb (<https://access.clarivate.com/>) é um *software* gerenciador de bibliografias para publicação de artigos científicos. Importa referências bibliográficas da Web, organiza-as em grupos de assuntos e insere as referências no corpo do texto, quando editado por processador Microsoft Office ou OpenOffice.

Foi realizada a busca e um primeiro corte geral de todo o material baixado das buscas eletrônicas, com exclusão das citações irrelevantes e ou duplicadas com apoio do *software* Rayyan. Posteriormente, dois revisores trabalharam de forma independente

(cegamento), na seguinte sequência: leitura geral dos títulos, resumos e termos descritores das citações baixadas para identificar estudos potencialmente elegíveis.

Em um próximo momento, foram obtidos artigos em texto completo para todas as citações identificadas como potencialmente elegíveis, quando então os revisores os examinaram independentemente e estabeleceram a relevância do estudo de acordo com a aplicação dos critérios de inclusão e exclusão.

As divergências quanto à elegibilidade de registros, foram solucionadas com um terceiro revisor, em reunião, quando se discutiram a elegibilidade em conjunto, examinaram os artigos em texto completo para consenso. Após a definição da amostra (estudos incluídos) a extração dos dados e avaliação do risco de viés foram realizadas.

4.3 Extração de dados

4.3.1 Formulário de extração de dados de interesse

A extração de dados foi realizada por dois revisores de forma independente com a utilização um formulário piloto padronizado (Apêndice B). As seguintes características foram extraídas de cada estudo incluído:

- ✓ Detalhes do estudo: citação completa, local do estudo, características do desenho do estudo e outros detalhes (autores, país, periódico etc) relevantes.
- ✓ Detalhes dos participantes: sexo, faixa etária (idade), etnia, status socioeconômico e tempo em situação de rua.
- ✓ Detalhes do cenário (considerando albergues/lares/abrigos): financiamento, capacidade, parcerias institucionais e assistência prestada.
- ✓ Detalhes da intervenção/ comparador: técnicas e desenho das intervenções, dinâmica, periodicidade, insumos utilizados.
- ✓ Detalhes dos desfechos: numeradores e denominadores associados a cada resultado; definições e descrições de resultados fornecidas em artigos; detalhes de como os resultados foram avaliados.
- ✓ Detalhes metodológicos: métodos de recrutamento, método de randomização caso seja ECR, número de participantes no estudo, comparabilidade dos grupos, critérios de inclusão e exclusão, duração do acompanhamento, perdas de acompanhamento ou desistências.

- ✓ Dados de avaliação de viés: Outros detalhes necessários para realizar uma avaliação de risco de viés usando a ferramenta *Cochrane's Collaboration Tool* descrita abaixo ou os critérios para estudos observacionais descritos posteriormente.
- ✓ Dados da Avaliação da Qualidade da Evidência.

4.4 Avaliação de risco de viés

4.4.1 Cochrane's Collaboration Tool/ NEWCASTLE-OTTAWA SCALE (NOS)

Para os ECR, foi utilizada a ferramenta de avaliação de viés descrita no *Cochrane Handbook* – “*Cochrane's Collaboration Tool*” – ROB II, e os não-ECR foram avaliados pela ferramenta ROBINS I (Higgins *et al.*, 2021). A abordagem Cochrane avalia o risco de viés em estudos individuais em seis domínios: geração de sequência, ocultação de alocação, mascaramento, dados de resultados incompletos, relatórios de resultados seletivos e “outros” vieses potenciais. Para tanto, os instrumentos consideram a seguinte graduação de risco de viés dos estudos (Quadro 4):

Quadro 4: Características definidoras dos níveis de enviesamento de estudos de acordo com a *Cochrane's Collaboration Tool*

I- Geração de sequência (verificação de viés de seleção)

- ✓ Baixo risco: os investigadores descreveram um componente aleatório no processo de geração de sequência, como o uso de uma tabela de números aleatórios, lançamento de moeda, embaralhamento de cartas ou envelopes.
- ✓ Alto risco: os investigadores descreveram um componente não aleatório no processo de geração da sequência, como o uso de data de nascimento ímpar ou par, algoritmo baseado no dia ou data de nascimento, número de registro hospitalar ou clínico. Ou: Nem um pouco randomizado.
- ✓ Risco pouco claro: informações insuficientes para permitir julgamento sobre o processo de geração da sequência.

II- Ocultação de alocação (verificação de viés de seleção)

- ✓ Baixo risco: os participantes e os pesquisadores que estão inscrevendo os participantes não podem prever a atribuição (por exemplo, alocação central;

ou envelopes numerados sequencialmente, opacos e lacrados).

- ✓ Alto risco: os participantes e investigadores que inscrevem os participantes podem prever as atribuições futuras (por exemplo, uma programação de alocação aleatória aberta, uma lista de números aleatórios) ou os envelopes não estavam lacrados, não eram opacos ou não eram numerados sequencialmente. Ou: alocação não oculta de forma alguma.
- ✓ Risco pouco claro: informações insuficientes para permitir o julgamento da ocultação da alocação ou do método não descrito.

III- Mascaramento (verificação de viés de desempenho e viés de detecção)

- ✓ Baixo risco: cegamento dos participantes, pessoal chave do estudo e avaliador de resultados, sendo improvável que o cegamento pudesse ter sido quebrado.
- ✓ Alto risco: sem mascaramento ou mascaramento incompleto quando o resultado provavelmente será influenciado pela falta de mascaramento.
- ✓ Risco pouco claro: informações insuficientes para permitir o julgamento da adequação ou não do mascaramento.

IV- Dados de resultados incompletos (verificação de possível viés de atrito por meio de retiradas, desistências, desvios de protocolo)

- ✓ Baixo risco: sem dados de desfecho ausentes, razões para dados de desfecho ausentes provavelmente relacionados ao desfecho verdadeiro ou dados de desfecho ausentes balanceados em número entre os grupos.
- ✓ Alto risco: motivo para dados perdidos de resultados provavelmente relacionados ao resultado verdadeiro, com desequilíbrio no número entre os grupos ou motivos para dados ausentes.
- ✓ Risco pouco claro: relatórios insuficientes de atritos ou exclusões.

V- Relatórios seletivos

- ✓ Baixo risco: um protocolo está disponível, e os resultados primários no relatório final do ensaio correspondem exatamente aos apresentados no protocolo.
- ✓ Alto risco: os resultados primários diferem entre o protocolo e o relatório final do ensaio.
- ✓ Risco pouco claro: nenhum protocolo de estudo está disponível ou a notificação é insuficiente para determinar se a notificação seletiva está presente.

VI- Outras formas de preconceito

- ✓ Baixo risco: nenhuma evidência de viés de outras fontes.
- ✓ Alto risco: potencial viés de outras fontes (por exemplo, interrupção precoce do estudo para benefício, atividade fraudulenta, desequilíbrio da linha de base entre os grupos de estudo, perda de acompanhamento igual a 20%, nenhuma análise para controlar possíveis fatores de confusão).
- ✓ Risco pouco claro: informações insuficientes para permitir o julgamento de outras formas de parcialidade. Para dados de resultado cegos e incompletos, várias entradas podem ser feitas se mais de um resultado (ou momento) estiver envolvido.

Fonte: Autor. Fortaleza, CE, Brasil, 2022.

Para efeito da avaliação dos estudos observacionais, o instrumento NEWCASTLE-OTTAWA SCALE (NOS) foi utilizado, especificadamente para estudos de caso-controle e coorte. Estudos que apresentem alto risco de viés ou não cumpram com as diretrizes propostas foram descontinuados e desconsiderados para efeito desta revisão.

4.5 Síntese de dados

4.5.1 Review Manager e GRADEpro

O software *Review Manager 5.4.1* (RevMan, 2020) fornecido pela *Cochrane Collaboration* foi utilizado para análise estatística. Foram calculadas as estimas de efeito e intervalos de confiança de 95% (IC95%) de cada estudo utilizando os modelos de efeito fixos e aleatórios. A medida de efeito adotada neste estudo refere-se ao risco relativo, calculado a partir da divisão das incidências de uso de preservativos entre o grupo intervenção e o grupo controle. Além disso, também foi calculado o efeito sumarizador dos estudos juntamente com seu IC95%.

A heterogeneidade entre os estudos foi avaliada por meio do Q de Cochran (teste qui-quadrado e p-valores) e pela estatística I^2 . O $I^2 < 25\%$ não indica heterogeneidade, entre 25% e 50% considera-se baixa heterogeneidade, entre 50% e 75% considera-se heterogeneidade moderada e $\geq 75\%$ alta heterogeneidade. O modelo de efeito fixo é considerado somente quando não há heterogeneidade entre os estudos avaliados; caso

contrário, opta-se pelo modelo de efeitos aleatórios (HIGGINS, WHITE, ANZURES-CABRERA, 2008; TENGAN *et al.*, 2020).

A verificação de viés de publicação se deu por meio do funnel plot e testes de Egger e Begg. Considera-se viés de publicação quando $p<0,05$ no teste (BEGG, MAZUMDAR, 1994).

O software *GRADEpro* (GRADEpro, 2020) fornecido pelo *GRADE Working Group* foi usado para produzir perfis de evidência GRADE. Para tanto, o sistema de qualificação de evidências da iniciativa GRADE usa os seguintes critérios em sua avaliação (GUYATT *et al.*, 2010):

I - Delineamento do estudo: Toda evidência proveniente de ensaios clínicos randomizados inicia com nível de evidência “Alto”. Evidências provenientes de estudos observacionais iniciam com nível de evidência “Baixo”, a não ser que a avaliação do risco de viés tenha sido realizada por meio da ferramenta ROBINS-I – nesse caso, o nível de evidência também inicia como “Alto”.

*** Fatores que podem reduzir a qualidade da evidência:**

II - Limitações metodológicas do estudo (risco de viés): limitações metodológicas indicam maior propensão a vieses, que são erros sistemáticos que causam distorções nos resultados de um estudo. Para avaliar esse domínio, primeiramente cada estudo deve ser avaliado por meio de ferramentas apropriadas, em seguida, se deve julgar a gravidade das limitações metodológicas considerando conjunto da evidência em questão. Caso haja risco de viés substancial nos estudos incluídos na avaliação do desfecho de interesse, pode haver penalização da qualidade da evidência em até dois níveis.

III - Inconsistência: Esse domínio avalia se os estudos que compõem o conjunto da evidência apresentam resultados discrepantes entre si. Para avaliar inconsistência, deve-se avaliar as estimativas de efeito de cada estudo, a sobreposição de seus intervalos de confiança e testes estatísticos como o I^2 . Caso haja inconsistência importante entre os estudos incluídos na avaliação do desfecho de interesse, pode haver penalização da qualidade da evidência em até dois níveis.

IV - Evidência indireta: A evidência pode ser considerada indireta nos casos em que a população, as intervenções, os comparadores ou os desfechos avaliados nos estudos

incluídos são diferentes daqueles definidos na questão de pesquisa da revisão sistemática. Nesses casos, pode haver penalização da qualidade da evidência em até dois níveis.

V - Imprecisão: O principal critério utilizado para avaliar a imprecisão de um resultado é a amplitude do intervalo de confiança de 95%. De forma simplificada, podemos considerar o intervalo amplo (e, portanto, a evidência imprecisa) quando a conclusão sobre a questão de pesquisa em análise difere entre as suas duas extremidades. O número de indivíduos e número de eventos também devem ser avaliados nesse domínio. Caso haja importante imprecisão nos estudos incluídos na avaliação do desfecho de interesse, pode haver penalização da qualidade da evidência em até dois níveis.

VI - Viés de publicação: O viés de publicação pode ser definido como a tendência de que estudos com resultados positivos tenham maior probabilidade de serem publicados, além de normalmente serem publicados antes, em revistas internacionais e em revistas indexadas em bases de dados como MEDLINE (e, portanto, de mais fácil acesso). Caso haja alta suspeita de viés de publicação para o desfecho em avaliação, a qualidade da evidência pode ser penalizada em até um nível.

***Fatores que podem aumentar a qualidade da evidência:** Se a qualidade da evidência não for penalizada por nenhum dos cinco fatores descritos anteriormente, podemos levar em consideração três fatores que podem aumentar a qualidade da evidência.

VII - Magnitude de efeito: Quando se observa efeitos de grande magnitude de forma consistente em estudos com poucos vieses e outras limitações, tem-se mais certeza no efeito observado. Nesses casos, a qualidade da evidência pode ser aumentada em até dois níveis.

VIII - Gradiente dose/intervenção-resposta: A presença deste gradiente é um achado que reforça a probabilidade da ocorrência de relação causa-efeito. Nos casos em que observamos um consistente aumento do efeito associado a um aumento na exposição, a evidência do efeito torna-se mais robusta e a qualidade da evidência pode ser aumentada em até um nível.

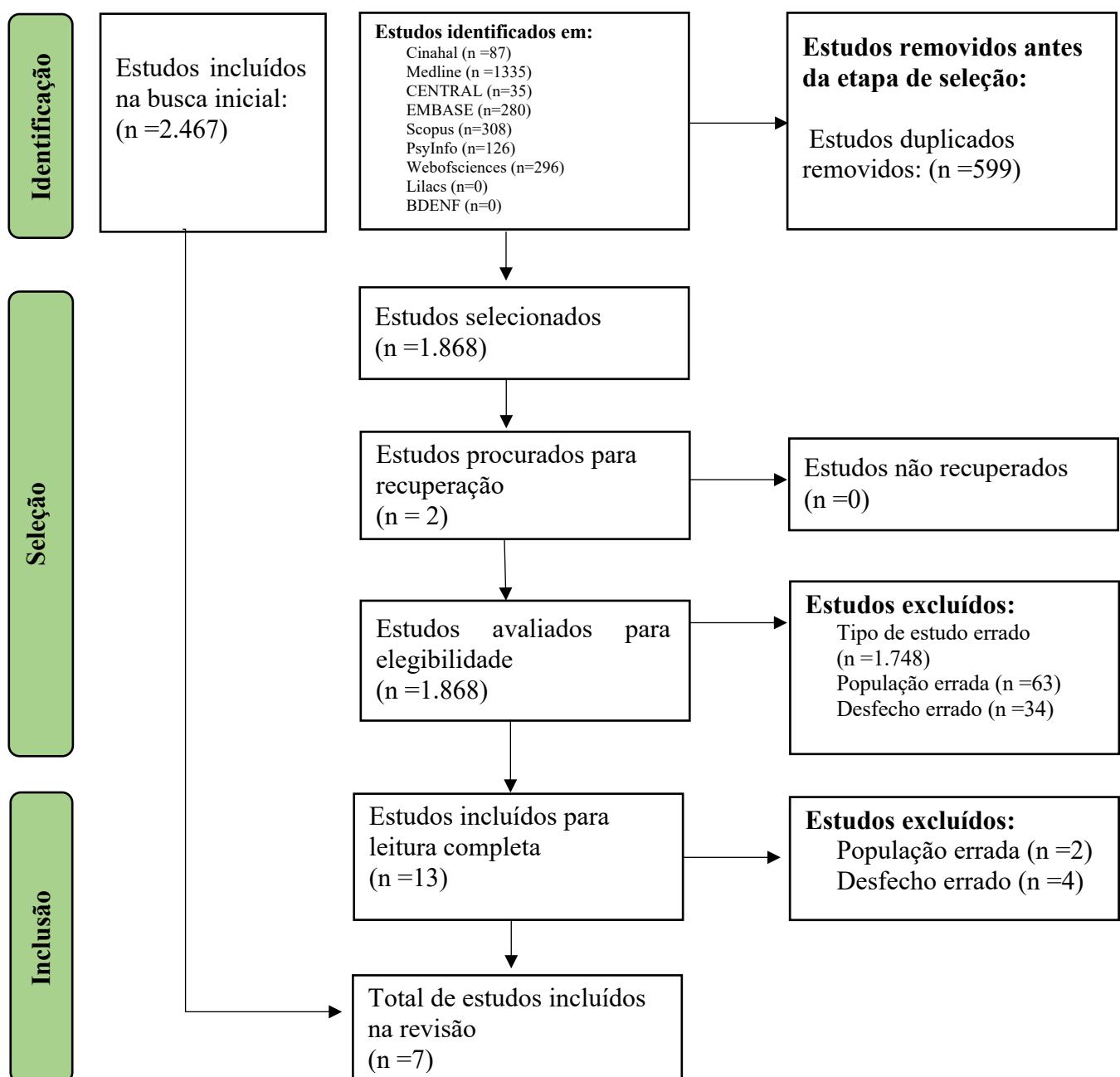
IX - Fatores de confusão residuais: Deve-se atentar a esse fator em dois casos: quando os fatores de confusão residuais superestimariam a estimativa de efeito e apesar disso não é encontrada associação; ou quando esses fatores subestimariam a estimativa de efeito, mas é observada uma importante associação. Nesses casos, a qualidade da evidência pode ser aumentada em até um nível.

5. RESULTADOS

5.1 Caracterização geral dos estudos e intervenções

As estratégias de busca resultaram em 2.467 artigos potencialmente relevantes. Depois de remover as duplicatas, que foram 599 artigos, foram então selecionados 1.868 artigos dos quais se avaliou 13 artigos em texto completo. Sete artigos foram incluídos no estudo (Figura 2).

Figura 2: Fluxograma de seleção dos estudos pela metodologia PRISMA



Fonte: Autor. Fortaleza, CE, Brasil, 2022. (PAGE *et al.*, 2021).

Os estudos incluídos apresentam predominância de realização nos Estados Unidos e em alguns países Africanos, com amostragem que variou 80 a 346 participantes e em sua maioria realizado em abrigos. Destes estudos incluídos seis são ECR e um é um estudo quase experimental do tipo antes e depois (Quadro 5).

Quadro 5: Características dos estudos incluídos quanto a referência, país, tipo de estudo, cenário, amostra, sexo e idade dos participantes.

| REFERÊNCIA | PAÍS | TIPO DE ESTUDO | CENÁRIO | AMOSTRA/ SEXO/ IDADE |
|---|----------------|---------------------------------------|-------------------------------|---|
| Slonim-Nevo, 2001. | Israel | Ensaio clínico randomizado | Centros residenciais de apoio | 139 participantes 89 mulheres/50 homens 13 a 17 anos |
| Rotheram-Borus <i>et al.</i> , 2003. | Estados Unidos | Ensaio clínico randomizado | Abrigo | 311 participantes 152 mulheres/159 homens 11 a 18 anos |
| Slesnick; Kang, 2008. | Estados Unidos | Ensaio clínico randomizado | Centro de acolhimento | 180 participantes 118 homens / 62 mulheres 14 a 22 anos |
| Norweeta <i>et al.</i> , 2012. | Estados Unidos | Ensaio clínico randomizado | Abrigo | 151 participantes 100 mulheres/51 homens 12 a 17 anos |
| Carmona <i>et al.</i> , 2014. | Estados Unidos | Ensaio clínico randomizado | Centro de acolhimento | 270 participantes 128 mulheres/ 142 homens 14 a 20 anos |
| Jennings; Ssewamala; Nabunya, 2016. | Uganda | Ensaio clínico randomizado | Abrigo | 346 participantes 225 mulheres/121 homens 10 a 17 anos |
| Embleton <i>et al.</i> , 2020. | Quênia | Estudo observacional (antes e depois) | Rua | 80 participantes 40 homens/40 mulheres 17 a 22 anos |

Fonte: Autor. Fortaleza, CE, Brasil.

As principais categorias de intervenções aplicadas aos adolescentes em situação de rua incluíram: 1) Sessões de aconselhamento, 2) Programas multiestratégias (terapia individual e familiar (por exemplo, terapia cognitivo-comportamental, entrevista

motivacional, terapia familiar e gerenciamento de casos) e 3) Reforço comunitário, como demonstrado no quadro 6.

Quadro 6: Caracterização das intervenções dos estudos incluídos quanto a referência, periodização e descrição das intervenções.

| REFERÊNCIA | PERIODIZAÇÃO | DESCRIÇÃO |
|--------------------------------------|--|---|
| Slonim-Nevo, 2001. | Sete sessões de duas horas cada, durante três semanas. Uma sessão de reforço foi aplicada dois meses após o final da última intervenção. | <p>Tipo: Intervenção educativa com aconselhamento</p> <p>Conteúdo: Informações sobre HIV/aids, aspirações futuras, uso de preservativos e atividade sexual mais segura.</p> <p>Aplicação da intervenção: Reuniões de grupo tipo roda de conversa baseada em aconselhamento coletivo. Os líderes de grupo usaram uma lista de verificação do conteúdo para auto monitorar as intervenções durante as reuniões do grupo, bem como um manual descrevendo detalhadamente o conteúdo e as atividades de cada sessão. Os participantes receberam um manual separado que indicava o conteúdo e as habilidades que deveriam ser lembradas em cada encontro. Os participantes do grupo de controle não receberam nenhum dos itens acima.</p> <p>Seguimento: semanal durante as intervenções, e final dois meses após a aplicação.</p> <p>Estratégia de adesão/permanência: oito semanas após o término da intervenção, os participantes receberam uma sessão de reforço com revisão do aconselhamento dado.</p> <p>Avaliação: Após a fase da coleta de dados (um ano), o entrevistador conversou pessoalmente com cada participante sobre prevenção de HIV/Aids, uso de preservativo e como prevenir a infecção.</p> |
| Rotheram-Borus <i>et al.</i> , 2003. | Reuniões três vezes por semana, durante três semanas. | <p>Tipo: Intervenção educativa com terapia individual e familiar e gerenciamento de casos.</p> <p>Conteúdo: Prevenção as IST e saúde mental/bem-estar.</p> <p>Aplicação da intervenção: Reuniões de pequenos grupos eram realizadas, geralmente à noite, e eram</p> |

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| | <p>co-lideradas por um pesquisador e um membro da equipe do abrigo. As sessões cobriram três áreas principais: cada sessão começou com a troca de elogios e relatos de sucesso no cumprimento das metas relacionadas ao HIV; foram apresentados o conteúdo e as novas atividades planejadas para aquela sessão em particular; e novas metas e trabalhos de casa foram estabelecidos. Cada sessão foi encerrada com expressões de apreço entre os membros do grupo. O conteúdo das 10 sessões de grupo aconteceu ao longo de três semanas. Semana 1: Oficinas de vídeo e arte, nas quais os jovens desenvolveram dramatizações de novelas, anúncios de serviço público, comerciais e raps sobre prevenção do HIV. Semana 2: Habilidades sociais com treinamento em assertividade e habilidades de enfrentamento que abordou as expectativas irrealistas dos fugitivos em relação às suas respostas emocionais e comportamentais em situações de alto risco. Os jovens foram ensinados a usar um “Termômetro do Sentimento” para identificar seus estados emocionais em situações com risco potencial de transmissão do HIV. Os jovens rotularam suas respostas afetivas em uma escala de 0 (confortável) a 100 (desconfortável) em resposta a uma grande variedade de situações e interpretando situações de risco com colegas. Os jovens foram então ensinados habilidades de auto-regulação para controlar sentimentos de ansiedade, depressão, raiva e desejo. Semana 3: As barreiras individuais ao sexo seguro foram revisadas em uma sessão de aconselhamento privado que visava atitudes disfuncionais e padrões de comportamento.</p> <p>Seguimento: semanal durante as intervenções, e um mês após a aplicação.</p> <p>Estratégia de adesão/permanência: recebimento de uma refeição gratuita e um passeio, além de participar de uma atividade em grupo planejada na agência. Além disso, recebiam \$1,00 por carregar um preservativo consigo e chegar no programa no horário. Fichas de agradecimento (<i>cards</i> feitos de cartolina de 1 polegada × 1 polegada) foram trocadas entre os membros do grupo como meio de sinalizar afeto positivo e comportamento desejado e apropriado, mas essas fichas não foram trocadas por recompensas tangíveis.</p> |
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| | | <p>Avaliação: Visitas semanais a uma agência local baseada na avaliação dos cuidados de saúde prestados pela comunidade a adolescentes.</p> |
| Slesnick; Kang, 2008. | 12 sessões, em um tempo total de quatro semanas. | <p>Tipo: Intervenção educativa com terapia individual e familiar e entrevista motivacional.</p> <p>Conteúdo: Prevenção de IST e autocuidado - educação e avaliação de risco sobre AIDS, redução de risco e prática de habilidades, assertividade sexual e prática de negociação, bem como autogestão comportamental e estratégias de resolução de problemas.</p> <p>Aplicação da intervenção: <u>Uso da abordagem de reforço comunitário.</u> Três blocos de sessões compuseram a intervenção: I - usada para estabelecer <i>rapport</i> (vínculo/acolhimento) e fornecer uma justificativa clara para a abordagem e para que os jovens sintam que o tratamento começou e que há esperança de melhorar sua situação de vida. II – Concentrou-se em um plano de tratamento provisório desenvolvido em colaboração ativa entre o terapeuta e o jovem. Assim, o plano visou as áreas de maior necessidade do cliente: habitação, cuidados médicos, procura de emprego, relações sociais, questões psiquiátricas (depressão, ansiedade) e problemas jurídicos. III - Para as sessões de três a 12, os terapeutas seguem estratégias de tratamento usando um conjunto padrão de procedimentos básicos e um menu de módulos de tratamento opcionais adequados às necessidades dos participantes¹. Para tanto, usou-se estrutura focada em quatro momentos (sessões)²: a primeira sessão foi dedicada à educação sobre AIDS e avaliação de risco. O jovem foi avisado de que a abstinência é a única maneira absoluta de permanecer não infectado. Dada a realidade de que muitos dos jovens já são sexualmente ativos, são abordadas formas de diminuir o risco de infecção pelo HIV (a educação visa promover a abstinência, mas reconhece que defesas menos eficazes são melhores do que nenhuma). A segunda sessão concentrou-se na redução de riscos e na prática de habilidades. Nesta sessão, o terapeuta discutiu com as jovens maneiras de evitar o risco de HIV, tanto os riscos sexuais quanto os de drogas, analisou os níveis individuais de risco e discute as barreiras ao uso do preservativo. Os jovens nesta sessão praticaram a aplicação de preservativos usando um modelo. A terceira sessão concentrou-se na assertividade sexual e na prática da</p> |

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| | | <p>negociação. As habilidades de comunicação e assertividade são ensinadas em três contextos: iniciar a discussão sobre preservativos com antecedência com um parceiro sexual, recusar pressão para praticar sexo desprotegido e recusar pressão para compartilhar agulhas. A sessão quatro concentrou-se na autogestão comportamental e nas estratégias de resolução de problemas. Foram discutidas situações passadas em que o jovem cedeu a pressões e situações indesejadas, pois essas situações podem ser difíceis de lidar no futuro.</p> <p>Seguimento: semanal durante as intervenções, e quatro meses após a aplicação.</p> <p>Estratégia de adesão/permanência: Dramatizações e tarefas de casa foram incorporadas às sessões para generalizar e praticar as habilidades recém-aprendidas. As sessões de três a 12 foram repetidas como forma de reforçar o conhecimento construído.</p> <p>Avaliação: não identificada no estudo.</p> |
| Norweeta et al., 2012. | Cinco sessões, durante um tempo total de cinco semanas | <p>Tipo: Intervenção educativa - <i>Support to Reunite, Involve and Value Each Other/</i>(STIVE) com terapia individual e familiar e entrevista motivacional.</p> <p>Conteúdo: Relações familiares, saúde sexual e autocuidado dos adolescentes: teorias cognitivo-comportamentais, projetadas para melhorar as habilidades de resolução de problemas e resolução de conflitos das famílias.</p> <p>Aplicação da intervenção: As sessões são baseadas em um conjunto de tarefas altamente interativas e semiestruturadas envolvendo <i>feedback</i> e prática com repetição enquanto duraram. A intervenção incluiu as seguintes ferramentas utilizadas durante as sessões de terapia: fichas para fortalecer comportamentos desejados, um termômetro de sentimentos para ensinar a regulação emocional, um modelo de resolução de problemas “pensar-sentir-fazer” para operacionalizar e enfrentar problemas, role <i>playing</i> para praticar com segurança novas habilidades, e reenquadramento para conceituar problemas e soluções de maneira não culpada. Um material instrucional foi criado para garantir a fidelidade. As sessões de intervenção geralmente duraram entre uma hora e meia e duas</p> |

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| | | <p>horas, e eram realizadas uma vez por semana. Todas as sessões foram gravadas em áudio e 20% foram videogravadas para garantia de qualidade.</p> <p>Estratégia de adesão/permanência: As habilidades aprendidas em uma sessão são constantemente reforçadas nas sessões subsequentes, de forma que condução das sessões de terapia buscam promover a aderência dos participantes durante sua aplicação.</p> <p>Seguimento: semanal durante as intervenções, e final 8 semanas após a aplicação.</p> <p>Avaliação: Um instrumento de classificação de 13 itens, referente aos temas discutidos na intervenção foi desenvolvido para avaliar a fidelidade ao conteúdo e objetivos da sessão.</p> |
| Carmona <i>et al.</i> , 2014. | Doze sessões durante quatro semanas | <p>Tipo: Intervenção educativa com <u>reforço comunitário</u>.</p> <p>Conteúdo: Os temas envolveram o uso de drogas e sexo seguro/prevenção as IST.</p> <p>Aplicação da intervenção: Uso de Abordagem de Reforço Comunitário³. Quatro terapeutas (psicólogos com dois a 10 anos de experiência nos temas) de nível de mestrado conduziram as intervenções. A Terapia de Aprimoramento Motivacional foi utilizada em duas sessões baseadas em uma versão adaptada da Entrevista Motivacional⁴, que procura aumentar a motivação intrínseca dos participantes. Jovens na condição de Gerenciamento de Casos receberam 12 sessões focadas em apoio e articulação para atender às suas múltiplas necessidades de serviços, incluindo necessidades básicas, saúde mental e física, apoio jurídico, educação e emprego. Todos os jovens receberam intervenção de HIV, independentemente de sua modalidade de tratamento de uso de substâncias. As sessões de HIV foram baseadas no programa “Tornando-se um Adolescente Responsável”⁵. A primeira etapa ofereceu aos jovens educação sobre AIDS, avaliação de risco, redução de risco e prática de habilidades. Os terapeutas discutiram a abstinência, as barreiras ao uso do preservativo e os níveis individuais de risco, incluindo comportamentos sexuais de risco e risco de uso de substâncias. Os jovens praticam a aplicação eficaz de um preservativo usando um</p> |

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| | | <p>modelo e melhoraram seus conhecimentos sobre saúde sexual. A segunda etapa visava melhorar as recusa e assertividade sexual e as habilidades de negociação. Os jovens dramatizam como discutir o uso de preservativos com antecedência com um parceiro, como recusar a pressão para se envolver em sexo desprotegido e como recusar o compartilhamento de agulhas. Além disso, os jovens discutem e encenam uma experiência anterior que envolveu aceitar a pressão como uma situação antecipada que pode ser difícil para eles lidarem no futuro.</p> <p>Seguimento: semanal durante as intervenções, e três meses após a aplicação da última sessão.</p> <p>Estratégia de incentivo/memorização: leituras e supervisão semanal durante o tempo das intervenções, além de reforço do conteúdo em sessão única antes das avaliações pré-intervenções.</p> <p>Avaliação: Avaliação continuas pré e pós intervenção não identificada no estudo.</p> |
| Jenning; Ssewamala; Nabuny, 2016. | Intervenção continua ao longo de 12 meses, com sessões mensais. | <p>Tipo: Intervenção educativa com aconselhamento.</p> <p>Conteúdo: prevenção ao HIV/aids e suporte social.</p> <p>Aplicação da intervenção: Os adolescentes do grupo controle receberam os serviços usuais, que incluíram: serviços de aconselhamento sobre saúde sexual, merenda escolar e materiais escolares (livros didáticos e uniformes). Os adolescentes do grupo de intervenção receberam os serviços habituais de cuidados, além de orientação mensal (orientação quanto ao uso do preservativo e as IST em sessões de aconselhamento), educação financeira e um depósito em dinheiro realizado em nome do adolescente. As economias acumuladas nos depósitos foram combinadas durante o período de intervenção de 12 meses com um limite de correspondência equivalente a US\$ 10 por mês.</p> <p>Seguimento: mensal durante as intervenções, e um mês após a aplicação.</p> <p>Estratégia de incentivo/memorização: não relatada.</p> <p>Avaliação: não identificada no estudo.</p> |
| Embleton <i>et al.</i> , 2020. | 24 sessões durante 14 semanas. | <p>Tipo: Intervenção educativa/comportamental (Programas <i>Stepping Stones</i> e <i>Criando Futuros</i>).</p> |

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| | <p><u>Baseada em terapia cognitivo-comportamental e motivacional entrevista.</u></p> <p>Conteúdo: identidade de gênero, HIV, habilidades de relacionamento e perspectivas pessoais. O programa <i>Stepping Stones</i> contemplou tópicos sobre: comunicação, normas de gênero, amor, saúde sexual e reprodutiva, HIV e IST, uso de preservativos, violência baseada em gênero, uso de drogas e álcool e pressão dos pares.</p> <p>Aplicação da intervenção: Oito semanas de <i>Stepping Stones</i> seguidas de seis semanas de Criando Futuros. Cada sessão de intervenção durou de uma hora a três horas e foi realizado em uma tenda particular fora da clínica Amiga do Adolescente. Os facilitadores de pares do mesmo sexo facilitaram o programa sob a supervisão do investigador principal, em grupos estratificados de 20 participantes por idade e por sexo. Os facilitadores eram membros respeitados e confiáveis da comunidade de rua, que passaram por um mês de treinamento sobre a intervenção, facilitação, condução da pesquisa e coleta de dados para este estudo.</p> <p>Seguimento: semanal durante as intervenções, e dois meses após a aplicação.</p> <p>Estratégia de incentivo/memorização: supervisão semanal enquanto duraram as sessões de intervenções e retomada de tópicos nos eixos temáticos da sessão de intervenção aplicada anteriormente.</p> <p>Avaliação: não identificada no estudo.</p> |
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1. MEYERS; SMITH, 1995.

2. B.A.R.T.; KELLY *et al.*, 1989; LAWRENCE *et al.*, 1995.

3. CRA; MEYERS; SMITH, 1995.

4. MILLER; ROLLNICK, 2002.

5. KELLY; LAWRENCE; HOOD; BRASFIELD, 1989; LAWRENCE; JEFFERSON; ALLEYNE; BRASFIELD, 1995.

Fonte: Autor. Fortaleza, CE, Brasil, 2022.

A nível de enviesamento dos estudos incluídos (ECR) foi alta e/ou moderada, sem grandes riscos de viés na maioria dos estudos incluídos (Quadro 7). Os domínios mais comuns com baixo risco foram os relacionados a ocultação da alocação e geração de sequencia aleatória e, em contrapartida o domínio relacionado a proteção as contaminações foi o que apresentou maior grau de não clareza, provavelmente relacionado a natureza das intervenções.

Quadro 7: Qualidade metodológica dos ECR incluídos de acordo com a ferramenta *Cochrane Risk of Bias*

| REFERÊNCIA | GERAÇÃO DE SEQUÊNCIA ALEATÓRIA | OCULTAÇÃO DE ALOCAÇÃO | DADOS DE RESULTADOS INCOMPLETOS | MASCARAMENTO | RELATÓRIOS DE RESULTADOS SELETIVOS | OUTROS RISCOS DE VIÉS | RISCO GERAL DE VIÉS |
|--------------------------------------|--------------------------------|-----------------------|---------------------------------|-------------------|------------------------------------|-----------------------|------------------------------------|
| Slonim-Nevo, 2001. | Risco pouco claro | Baixo risco | Baixo risco | Baixo risco | Risco pouco claro | Risco moderado | Sem grandes riscos de enviesamento |
| Rotheram-Borus <i>et al.</i> , 2003. | Baixo risco | Baixo risco | Baixo risco | Risco pouco claro | Risco pouco claro | Risco moderado | Risco moderado de enviesamento |
| Slesnick; Kang, 2008. | Baixo risco | Baixo risco | Baixo risco | Risco pouco claro | Baixo risco | Baixo risco | Sem grandes riscos de enviesamento |
| Norweeta <i>et al.</i> , 2012. | Baixo risco | Baixo risco | Baixo risco | Baixo risco | Baixo risco | Baixo risco | Sem grandes riscos de enviesamento |
| Carmona <i>et al.</i> , 2014. | Baixo risco | Baixo risco | Risco pouco claro | Baixo risco | Baixo risco | Risco moderado | Sem grandes riscos de enviesamento |
| Jenning; Ssewamal; Nabuny, 2016. | Baixo risco | Baixo risco | Baixo risco | Risco pouco claro | Baixo risco | Baixo risco | Sem grandes riscos de enviesamento |

Fonte: Autor. Fortaleza, CE, Brasil, 2022.

O estudo de Embleton *et al.* (2020), foi avaliado separadamente por não se tratar de um ECR e não ter sua aplicabilidade no instrumento *Cochrane Risk of Bias*. O estudo não apresentou enviesamento considerável conforme demonstrado no Quadro.

Quadro 8: Qualidade metodológica dos ECR incluídos de acordo com a ferramenta *NEWCASTLE - OTTAWA QUALITY ASSESSMENT SCALE*.

| REFERÊNCIA | CRITÉRIO | PONTUAÇÃO | RISCO DE VIÉS |
|-------------------------------|--|-----------|---------------|
| Embleton <i>et al.</i> , 2020 | Representatividade da amostra exposta | * | Baixo |
| | Seleção da amostra não exposta | * | Baixo |
| | Apuração da exposição | * | Baixo |
| | Demonstração de que o resultado de interesse não estava presente no início do estudo | * | Baixo |
| | Comparabilidade de grupos com base no desenho ou análise | * | Moderada |
| | Avaliação do resultado | * | Baixo |

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| | O acompanhamento foi longo o suficiente para que os resultados ocorressem | * | Baixo |
| | Adequação do acompanhamento dos grupos | * | Baixo |

Fonte: Autor. Fortaleza, CE, Brasil, 2022.

Relacionado ao perfil da evidência, tendo como base os elementos considerados pela abordagem GRADE, nos estudos incluídos tiveram perfil de evidencia considerado alto e moderado, sendo predominantes como observado no Quadro 9.

Quadro 9: Avaliação dos perfis de evidência GRADE.

| CRITÉRIOS | REFERÊNCIA | PERFIL DA EVIDÊNCIA |
|--|--------------------------------------|---|
| I-Delineamento do estudo | Slonim-Nevo, 2001. |  (ALTO) |
| II- Limitações metodológicas (risco de viés) | Rotheram-Borus <i>et al.</i> , 2003. |  (MODERADO) |
| III- Inconsistência | Slesnick; Kang, 2008. |  (ALTO) |
| IV- Evidência indireta | | |
| V - Imprecisão | Norweeta <i>et al.</i> , 2012. |  (MODERADO) |
| VI - Viés de publicação | | |
| VII - Magnitude de efeito* | Carmona <i>et al.</i> , 2014. |  (ALTO) |
| VIII - Gradiente intervenção-resposta* | Jennings; Ssewamala; Nabunya, 2016. |  (ALTO) |
| IX - Fatores de confusão residuais* | Embleton <i>et al.</i> , 2020. |  (MODERADO) |

*Aumentam o perfil de evidência

Fonte: Autor. Fortaleza, CE, Brasil, 2022.

5.2 Caracterização geral dos achados dos estudos

5.2.1 Sessões de aconselhamento

As sessões de aconselhamento foram as estratégias adotadas nas intervenções de dois dos estudos incluídos nesta revisão. Os mesmos, utilizaram-se do aconselhamento como ferramenta guia para a aplicação das intervenções com enfoque geral nas IST, incluindo na prevenção das mesmas através do uso do preservativo. Os achados de interesse são apresentados no quadro 8.

Quadro 10: Descrição dos estudos com intervenção baseada em aconselhamento quanto a referência, aos desfechos e implicações clínicas

| REFERÊNCIA | DESFECHOS | IMPLICAÇÕES CLÍNICAS |
|------------------------------------|---|---|
| Slonim-Nevo, 2001. | O grupo intervenção evidenciou mais conhecimento ($p < 0,005$) e melhores habilidades de enfrentamento/uso do preservativo ($p < 0,01$) do que os participantes do grupo controle, após as sessões de intervenção, e 12 meses depois. Em relação às atitudes, na fase pré-intervenção, o grupo controle apresentou atitudes mais positivas em relação à prevenção do que o grupo tratamento ($p < 0,005$), mas após a intervenção e 12 meses depois, essa diferença diminuiu. | O grupo intervenção melhorou suas atitudes de proteção sexual ao longo do tempo, enquanto seus pares (grupo controle) permanecem inalterados. |
| Jennings; Sewamala; Nabunya, 2016. | Ambos os grupos (intervenção e controle) tiveram os escores atitudinais de prevenção do HIV/uso do preservativo no início do estudo baixos a moderados. As atitudes de prevenção do HIV/uso do preservativo afirmadas no início do estudo foram 73,2% (grupo intervenção) e 70,6% (grupo controle). O escore atitudinal médio de prevenção ao HIV/uso do preservativo aumentou significativamente no grupo de intervenção desde a linha de base até 12 meses ($p < 0,001$) e | O grupo intervenção teve 2,017 chances significativamente maiores de uso do preservativo ao longo do tempo. Notou-se também mudanças significativas, porém menores, para o uso do preservativo ao longo do tempo no grupo controle. |

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| | de 12 a 24 meses ($p < 0,001$) resultando em um aumento líquido significativo de +1,0 ponto ($p < 0,001$). Uma mudança líquida menor, mas significativa, foi observada nos escores médios de prevenção ao HIV no grupo controle ($p < 0,001$) como resultado de um ganho significativo em 12 meses ($p < 0,001$) que foi atenuado por um declínio em 24 meses ($p > 0,05$). | |
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Fonte: Autor. Fortaleza, CE, Brasil, 2022.

5.2.2 Programas multiestratégias

As intervenções multiestratégias (uso combinado de 2 ou mais estratégias) descritas em quatro estudos incluídos nesta revisão, contemplaram estratégias como a terapia cognitivo-comportamental (TCC), motivacional entrevista (MI), terapia familiar e gerenciamento de casos (Quadro 9).

Quadro 11: Descrição dos estudos com intervenções baseadas terapia cognitivo-comportamental (TCC), motivacional entrevista (MI), terapia familiar e gerenciamento de casos quanto a referência, aos desfechos e implicações clínicas.

| REFERÊNCIA | DESFECHOS | IMPLICAÇÕES CLÍNICAS |
|--------------------------------------|--|---|
| Rotheram-Borus <i>et al.</i> , 2003. | <p>Os participantes do sexo feminino do grupo intervenção, em comparação com os do grupo controle, teve o número médio de atos sexuais desprotegidos menor no seguimento de 3 meses ($p = 0,055$) e foi significativamente menor no seguimento de 24 meses ($p = 0,018$).</p> <p>Não houve diferenças significativas com base no número de atos sexuais desprotegidos entre os participantes do sexo masculino. Números mais altos de atos sexuais vaginais e anais desprotegidos no início do</p> | O grupo intervenção apresentou maior adesão ao uso do preservativo nos seguimentos 6 e 12 meses, entretanto o uso declinou nos seguimentos 18 e 24 meses, demonstrando que ao longo do tempo a eficácia das intervenções apresenta queda. |

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| | <p>estudo foram relacionados a números mais altos de atos sexuais desprotegidos nos acompanhamentos entre os participantes do sexo masculino ($p = 0,043$).</p> | |
| Slesnick; Kang, 2008. | <p>Os grupos controle e intervenção mostraram aumento no uso de preservativos 6 meses após a linha de base em comparação com a linha de base (mês 0). Os resultados mostraram uma redução nos comportamentos relacionados ao uso do preservativo a partir da linha de 6 meses após a linha de base em ambos os性os no grupo intervenção. As médias gerais para a frequência de uso de preservativo e da avaliação de conhecimento sobre o HIV aumentou ao longo tempo entre o grupo intervenção. O teste post-hoc indicou que os adolescentes do grupo intervenção relataram uso mais frequente de preservativos (Média = 4,07, Erro Padrão = 0,22) do que os em tratamento habitual (Média = 3,04, Erro Padrão = 0,22).</p> | <p>O grupo controle apresentou o resultado menos favorável (usou camisinha com menos frequência 6 meses após a linha de base), indicando que o grupo intervenção tem maior frequência no uso do preservativo.</p> |
| Norweeta et al., 2012. | <p>Análises de intenção de tratar foram realizadas para estimar o impacto da intervenção STRIVE nos comportamentos de risco nos 3 meses anteriores a cada avaliação. Nenhum efeito de intervenção significativo foi encontrado para o uso do preservativo pelos adolescentes sexualmente ativos. Os adolescentes do grupo intervenção não eram significativamente mais propensos a ter relações sexuais (53% vs. 46%; NS), mas eram propensos a usar preservativo se o fizessem assim como os do grupo controle (45% vs. 41%; $p= 0.05$).</p> | <p>O grupo intervenção apresentou redução do uso de drogas e álcool, entretanto não apresentou resultados significativos no aumento do uso do preservativo. O grupo controle não apresentou melhora na redução de riscos e uso do preservativo. Os autores sugerem que o estudo deve ser replicada para determinar sua eficácia como intervenção para saúde sexual entre adolescentes em situação de rua.</p> |

| | | |
|--------------------------------|--|---|
| Embleton <i>et al.</i> , 2020. | <p>No início do estudo, a pontuação média do CUSE (aderência e autoeficácia no uso do preservativo) foi de 20,7 (DP 4,6). Após a intervenção, a pontuação média do CUSE demonstrou um pequeno aumento não significativo (21,4, SD 4,3) com pontuações semelhantes entre os sexos. O uso relatado de preservativo na última relação sexual foi baixo entre todas as participantes pré e pós-intervenção (35%). Pós-intervenção houve aumento na proporção de homens que relataram uso de preservativo na última relação sexual, embora não estatisticamente significativo. Da mesma forma, houve um pequeno aumento não significativo na porcentagem de participantes do sexo masculino que relataram usar preservativos sempre ou na maior parte do tempo, enquanto isso não mudou significativamente para mulheres.</p> | <p>Não houve aumento significativo no uso e conhecimento sobre preservativos, e, outras práticas性uais permaneceram geralmente inalterados após a intervenção.</p> |
|--------------------------------|--|---|

Fonte: Autor. Fortaleza, CE, Brasil, 2022.

5.2.3 Reforço comunitário

A intervenção aplicada em um dos estudos nesta revisão utilizou uma abordagem de terapia comportamental, que originalmente é usada na psicoterapia para o tratamento de vícios/desenvolvimento de hábitos de vida mais saudáveis e foi desenvolvida por Robert J. Meyers no final dos anos 1970 (MEYRS *et al.*, 1970). Os achados de interesse deste estudo são apresentados no quadro 12.

Quadro 12: Descrição dos estudos com intervenção baseada no reforço comunitário quanto a referência, aos desfechos e implicações clínicas.

| REFERÊNCIA | DESFECHOS | IMPLICAÇÕES CLÍNICAS |
|-------------------------------|---|--|
| Carmona <i>et al.</i> , 2014. | Testes de qui-quadrado revelaram um aumento significativo maior na porcentagem dos adolescentes do grupo intervenção usando preservativo desde a linha de base até os 6 meses de seguimento [$\chi^2(1) = 5,39$, $p = 0,05$], mas não desde a linha de base até os 12 meses acompanhamento [$\chi^2(1) = 0,15$, $p > 0,05$], em comparação ao grupo controle. A maior frequência de uso de drogas no início do estudo foi associada a uma probabilidade marginalmente menor de apresentar uma frequência de uso de preservativo reduzida e uma probabilidade significativamente maior de apresentar uma frequência de uso de preservativo aumentada do que não apresentar nenhuma alteração. A maior frequência ao tratamento (intervenção) foi associada a uma probabilidade significativamente menor de apresentar menor frequência de uso do preservativo do que nenhuma mudança ($OR = 0,22$; IC 95%: 0,05–0,93). | Os adolescentes com maior frequência de uso de drogas na linha de base e aqueles que participaram de mais sessões de tratamento foram menos propensos a apresentar menor frequência de uso de preservativo e mais propensos a exibir maior frequência de uso de preservativo no seguimento de 6 meses, mas declinou no seguimento 12 meses. Isto posto, demonstra que a intervenção não mantém sua eficácia ao longo do tempo. |

Fonte: Autor. Fortaleza, CE, Brasil, 2022.

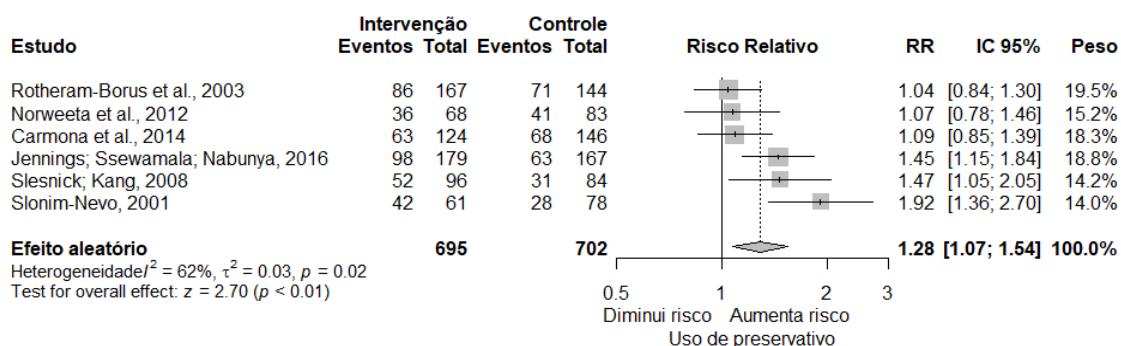
5.3 Eficácia e viés das intervenções

Seis estudos foram inseridos na metanálise. Estes representaram um total de 1397 casos investigados, onde 695 fizeram parte do grupo experimento e 702 do grupo controle. Por meio do Q de Cochran observou-se diferença significativa entre os estudos

$Q(5)=13,1$; $p=0,02$; além disso, a análise apresentou $I^2=62\%$, ambos indicativos de heterogeneidade. Dessa forma, escolheu-se o modelo de efeitos aleatórios.

Por meio deste modelo, identificou-se que as pesquisas apresentaram pesos semelhantes, com destaque para a de Rotheram-Borus *et al.* (2003) que mostrou 19,5% do peso das investigações. Assim, por meio da metanálise evidenciou-se que as intervenções aumentaram o uso de preservativo em 28% (IC95%: 1,07 – 1,54; $p<0,01$) e apresentam eficárias semelhantes em sua maioria (Figura 3).

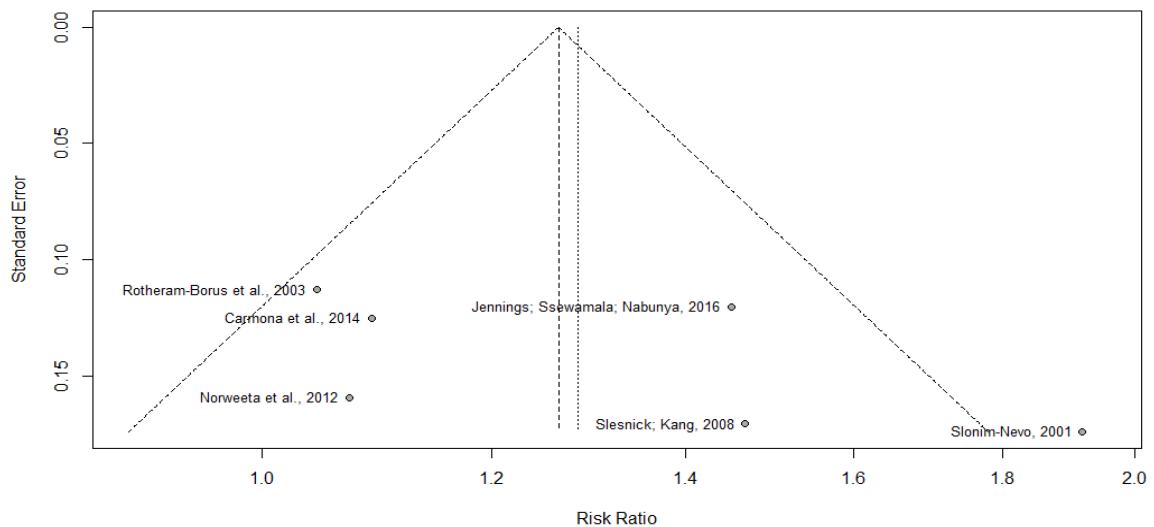
Figura 3: Metanálise das intervenções educativas para promoção do uso do preservativo entre adolescentes em situação de rua



Fonte: Autores, (*Review Manager 5.4.1*), Fortaleza, CE, Brasil, 2022.

Por meio do *funnel plot* (Figura 4) observou-se baixo risco de viés de publicação dentre os estudos analisados. Este achado foi confirmado tanto pelo teste de Egger [$t(4)=1,34$; $p=0,25$] e Begg ($z=1.69$; $p=0,10$), que consideraram não haver viés de publicação significante. Entretanto, como somente seis artigos foram incluídos na metanálise, os resultados dos testes devem ser interpretados com cautela devido o baixo poder quando $n<10$ estudos.

Figura 4: Risco de enviesamento das intervenções educativas para promoção do uso do preservativo entre adolescentes em situação de rua



Fonte: Autores, (*Review Manager 5.4.1*), Fortaleza, CE, Brasil, 2022.

6. DISCUSSÃO

6.1 - Intervenções summarizadas

Identificou-se várias intervenções aplicadas para adolescentes que vivenciam a situação de rua com muitos riscos e vulnerabilidades. Neste sentido, a dinâmica desse público é complexa; os caminhos para a moradia são precários, os antecedentes socioculturais estão se tornando cada vez mais diversos e os recursos disponíveis são inconsistentes (BROWN *et al.*, 2021). Os estudos apresentaram eficácia em sua maioria abaixo do esperado, o que pode sugerir que as ferramentas metodológicas aplicadas nas intervenções podem não ser de tanta valia quanto ao uso do preservativo entre os adolescentes em situação de rua.

As intervenções que compuseram a amostra mostraram que relações familiares instáveis são a base das problemáticas vivenciadas pelos adolescentes em situação de rua, e muitos deixaram seus lares por sofrerem violência interpessoal e abuso (MARRONE *et al.*, 2020). Dentre as difíceis questões familiares, surgem outras pessoais (abandono escolar, falta de moradia, marginalização social) decorrentes de seus contextos ambientais, que podem levar ao aumento do sofrimento.

Estes fatores configuram-se como potencializadores de diversas situações de vulnerabilidades, tendo em vista que aumentam as chances para adoção de comportamentos de risco que, muitas vezes, os levam ao uso de substâncias, depressão e deficiência, e podem contribuir para a exposição a IST e comportamentos sexuais inseguros (NYABRYEN *et al.*, 2020).

Os estudos (GAUVIN *et al.*, 2019; DEMENECH *et al.*, 2021; REEVES *et al.*, 2021) demonstram que populações jovens em situação de rua (15 a 25 anos) relatam problemas de saúde sexual ao acessarem serviços de saúde mental, uma vez que apresentam taxas mais altas de comportamento sexual de alto risco e gravidez indesejada do que seus pares sem doença mental. Ratifica-se a importância das intervenções incluídas, uma vez que as intervenções mostraram-se eficazes, principalmente, aquelas que utilizaram abordagens comportamentais e baseadas em terapia individual e familiar.

Identificar estratégias de intervenção para uso de preservativo com adolescentes em situação de rua, é uma importante prioridade para as ações de saúde no contexto do Sistema Único de Saúde-SUS, devido à redução significativa dos custos financeiros e sociais associados a necessidade de diminuir os altos níveis de riscos e infecções (BARATON *et al.*, 2018). Os estudos incluídos nesta revisão sistemática demonstram

que os esforços operados pelas intervenções em saúde, ratificam que a PSR enfrenta dificuldades para alcançar os cuidados em saúde, e maior dificuldade de construir mudança comportamental positiva.

As intervenções de aconselhamento, terapia individual/familiar, reforço comunitário e entrevistas motivacionais elencadas configuram-se como ferramentas com potencial para contribuir com adoção de comportamentos mais protetivas (uso do preservativo, aumento do seu letramento em saúde e solidificação de autocuidado sexual) na saúde dos adolescentes em situação de rua. Sabe-se que esse público é mais propenso a comportamentos vulneráveis, o que os deixa susceptíveis ao uso de álcool/outras substâncias, ter múltiplos parceiros, sexo desprotegido e com isso, correm maior risco de IST, (JOHARI *et al.*, 2022), portanto é fundamental a adoção de ações preventivas eficazes.

Elucida-se a necessidade das intervenções educativas para saúde sexual dos adolescentes em situação de rua, uma vez que são mais propensos a se envolverem em sexo sob a influência de drogas (*chemsex*), o que significa que existem fatores de risco específicos associados ao comportamento, necessitando de intervenções direcionadas e culturalmente adequadas para este grupo (OLIVEIRA *et al.*, 2020).

É importante mencionar que sexualidade pode ser compreendida como o desejo de contato, calor, carinho ou amor, sendo um fenômeno da existência humana, presente na vida de adolescentes (GUIMARAES; CABRAL, 2022). Desse modo, as intervenções que compuseram a amostra desse estudo, buscam tornar a vivencia segura e preventiva da sexualidade neste grupo populacional mostram-se oportunas e necessárias.

É fundamental que na família, o diálogo sobre sexualidade e sexo, no geral, ainda é tabu. Entre as famílias de adolescentes em situação de rua não é diferente, porém, agregado a essa falta de diálogo, eles contam com dificuldades de relações familiares, a saída de casa e a permanência nas ruas, com isso, aumentam as vulnerabilidades e os riscos, aos quais estão expostos (DANZMANN *et al.*, 2022).

Percebeu-se que os contextos e cenários em que foram aplicadas as intervenções, que os adolescentes que vivenciam a situação de rua passam por vulnerabilidades sociais que dificultam a captação de conhecimentos e não favorecem processos de aprendizagem, tem a exposição ao sexo desprotegido e IST maximizada.

Os adolescentes adquirem informações relacionadas a sexualidade predominantemente com amigos, revistas, filmes, televisão e internet, e com menos frequência com professores e profissionais de saúde (AMARAL *et al.*, 2017), o que valida

a relevância e mérito das intervenções, como forma de oferta de conhecimentos de saúde sexual aos adolescentes através de profissionais da saúde/educadores.

É notório que as intervenções summarizadas, buscam além do aumento de comportamentos sexuais protetivos (uso do preservativo como foco), aumentar a capacidade de autogestão do risco sexual individual dos adolescentes, buscando através da construção do conhecimento, fomentar a sua autonomia de cuidado.

A autonomia, nesse sentido, é discutida levando em consideração dois aspectos: a liberdade e a qualidade do agente. É necessária a garantia de que todo participante possa ter a liberdade de escolha, sem sofrer nenhuma coerção, e de ausência de influências na tomada de decisão. Já a qualidade do agente se refere à capacidade de agir intencionalmente e requer o entendimento da situação, ou seja, ter a compreensão cognitiva dos objetivos, riscos e benefícios (ALBUQUERQUE e GARRAFA, 2016).

Portanto, todas as intervenções com suas abordagens e metodologias empregadas em sua aplicação, objetivaram construir comportamentos preventivos de saúde nos adolescentes em situação de rua, através da oferta de informações e estratégias para construir e/ou modificar seus comportamentos em relação a saúde sexual.

6.2 - Desfechos e implicações clínicas

6.2.1 Considerações gerais

Em relação às terapias individuais e familiares, as intervenções com sessões de aconselhamento, mostraram melhorias no desfecho de uso do preservativo. Dentre as intervenções de apoio estrutural, os serviços de acolhimento e capacitação não aumentaram ou modificaram o uso do preservativo.

Aponta-se que os estudos (ROTHERAM-BORUS *et al.*, 2003; SLESNICK; KANG, 2008; CARMONA *et al.*, 2014) possuem perfil de evidência moderado/alto e que isto possa estar relacionado ao fato das intervenções realizadas ou o cenário/duração possam estar ligados a menor eficácia das mesmas.

Quanto as intervenções multiestratégias (uso combinado de duas ou mais metodologias na composição da intervenção) e as de terapia comunitária demonstram aumento do uso do preservativo, entretanto com menor eficácia. Entrevistas motivacionais, programas de capacitação e gestão de casos mostraram efeitos

inconsistentes e/ou com menor impacto no uso do preservativo quando comparados com os serviços habituais e outras intervenções.

As intervenções buscaram além do uso do preservativo como foco, *starts* no diz respeito para necessidade de atentar para a sexualidade dos adolescentes, que é uma necessidade que pode contribuir para reduzir problemas no que diz respeito à sua vida pessoal e social (ARAGÃO *et al.*, 2018). Reforça-se que o valor da educação sexual para a sexualidade (ambiente pouco explorado nos estudos inseridos nesta revisão), não limitando-se a anatomia e fisiologia do corpo ou aos métodos de prevenção (preservativos) e as IST.

6.2.1 Aconselhamento

Dois estudos desta revisão incluíram intervenções baseadas no aconselhamento para adolescentes como uma ferramenta de apoio psicoeducacional (OMS, 1985), validando-o como evidências, que podem ser uma estratégia comprovadamente eficiente para alcançar a mudança comportamental no aumento do uso do preservativo.

Como uma atividade psicossocial, o aconselhamento tem potencial para promover a mudança de hábitos e comportamentos com impacto positivo na saúde (KLUSSE, 2020; MUECKE *et al.*, 2021). Utilizado em intervenções elencadas nesta revisão, o aconselhamento buscou, seguindo as diretrizes do Serviço de Saúde Pública que (PARK *et al.*, 2020), promover de forma intensiva com número de sessões variadas e envolvimento em sessões mensais de reforço, solidificar o conhecimento e mudança de comportamento sexual entre os adolescentes em situação de rua.

Cabe mencionar que uma das finalidades do aconselhamento é promover a saúde e prevenir a doença, por isso a educação é um componente essencial que dela faz parte, para alcançar mudanças positivas nos comportamentos de saúde (KLUSSE, 2020; DICLEMENTE, 2021). A construção de hábitos/comportamentos, é muito importante, a considerar que estudos (SILVA, 2020; STORKY *et al.*, 2021; XIN *et al.*, 2021) mostram que os comportamentos aprendidos na adolescência são uma parte importante do perfil de saúde do adulto e que muitas patologias adultas têm origem em comportamentos adquiridos na vida, sendo a intervenção educativa nesta fase a que produz melhor impacto preventivo.

A sumarização destas intervenções, permitiu identificar que o aconselhamento buscou além da mudança comportamental, tornar os adolescentes mais capazes de

autogerir seus riscos sexuais, o que torna possível a relação paralela com o aumento da autoeficácia, ideia defendida por Bandura, em que a pessoa torna-se confiante sobre sua capacidade de realizar um comportamento de forma eficaz, e isso influencia na sua motivação e esforços, na realização de uma tarefa específica, e no estabelecimento de metas individuais e perspectiva (apud SHOREY *et al.*, 2019).

Por fim, reflete-se que entre os fatores apontados como obstáculos nas intervenções com aconselhamento, uma atividade que se propõe a mudar comportamentos e reconhece explicitamente sua importância nos programas de atenção à saúde de adolescentes, é desenvolvido como uma ação sem integração com políticas públicas. Para isso, sem um trabalho multidisciplinar focado em problemas de saúde, perde-se a oportunidade de fortalecimento do aconselhamento ofertado pelos profissionais de cuidados em saúde (PARK *et al.*, 2020; GONÇALVES; MORAES; SILVA, 2022).

6.2.2 Programas multiestratégias

Quatro estudos desta revisão utilizaram intervenções baseadas em programas multiestratégias. Tais programas usam duas ou mais metodologias no desenvolvimento das intervenções, tendo como base fundamental: terapia cognitivo-comportamental e familiar, entrevista motivacional e gerenciamento de casos.

As terapias cognitivas-comportamentais e familiares incorporam um foco na terapia dos pais/família para abordar as necessidades terapêuticas e dos adolescentes como por exemplo: bem-estar dos pais, comportamentos de riscos ao uso de drogas, álcool, exposição sexual e estresse familiar (KEENAN-MILLER *et al.*, 2012; SCHENKEL *et al.*, 2008).

Nas intervenções elencadas nesta revisão, observou-se que apesar de não projetadas em específico para uso somente do preservativo, estas intervenções visam de forma adjunta melhorar os relacionamentos familiares e redução do uso de álcool e drogas.

Os componentes centrais das intervenções que utilizaram estas abordagens englobaram processos afetivos, cognitivos e familiares e individuais na promoção de comportamentos visando: melhorar a regulação do afeto, aumentar a resolução de problemas, esperança, autocuidado, autoestima; e melhora na adaptabilidade e conflitos familiares (WEINSTEIN *et al.*, 2019).

As intervenções que tiveram características psicossociais podem facilitar a aquisição de habilidades de jovens de alto risco para lidar com o estresse, autocuidado, desenvolver suportes sociais e alcançar autonomia.

Estas abordagens estão demonstradas na literatura, e destaco um estudo piloto de um ensaio clínico randomizado de dois locais de 40 jovens com sintomas ativos de transtorno depressivo. Através deste piloto, o principal achado revelou que a terapia na família para jovens de alto risco baseada em sessões de psicoeducação com treinamento de habilidades de comunicação e treinamento de habilidades de resolução de problemas, estava associada a uma recuperação mais rápida dos sintomas de humor, mais tempo em remissão e uma trajetória mais favorável dos sintomas de hipomania (MIKLWITZ *et al.*, 2020).

Vale destacar que as jornadas de recuperação e/ou mudança de comportamento são relacionais e bidirecionais, pois as famílias influenciam a jornada de recuperação de uma pessoa e a jornada de recuperação impacta a família (TUNGUNKOM *et al.*, 2017; WARD *et al.*, 2017).

A entrevista motivacional, definida por Rollnick e Miller (2001), como um método de aconselhamento que busca estimular e fomentar posturas proativas aos clientes e que tem sido usada com sucesso para provocar e sustentar as mudanças de comportamento de uma pessoa em várias áreas da saúde.

Esta abordagem também já vem sendo usada não somente no contexto da mudança de comportamento sexual relacionado ao uso do preservativo, o que demonstra a sua usabilidade em outros contextos comportamentais. Prova disso, está em duas revisões recentes que mostraram melhorias no comportamento de saúde em pacientes com diabetes (SODERLUND, 2017; FROST *et al.*, 2018; MINET, 2020).

Outra possibilidade diz respeito a entrevista motivacional, que como IE, visa apoiar a autoeficácia dos indivíduos demonstrando uma abordagem empática para ajudar a analisar suas contradições na mudança comportamental e garantir que os indivíduos alcancem a mudança comportamental, fatores estes que são observados nas intervenções incluídas neste estudo (SELÇUK-TOSUN; ZINCIR, 2019).

Os resultados desta revisão também sugerem que as sessões de entrevista motivacional devem ter como alvo um número mínimo de comportamentos de autogestão, ser ministradas por conselheiros proficientes em entrevista motivacional e usar protocolos de entrevista motivacional com ênfase na duração ou na frequência das sessões.

Entende-se que a entrevista motivacional é um método de entrevista centrado no cliente e recomendado para garantir a mudança comportamental, ajudando os pacientes a conhecer e resolver seus problemas. Além disso, este método é uma técnica de comunicação eficaz para profissionais da saúde vislumbrando a mudança de comportamento inadequado para um comportamento saudável aos seus pacientes (DOGRU *et al.*, 2019).

Considerando as intervenções buscam a mudança no comportamento sexual (uso do preservativo), destaca-se que o gerenciamento de casos responde às necessidades complexas dos pacientes e visa promover o autogerenciamento do cuidado sendo seu uso válido e oportuno (JI *et al.*, 2019; BRAZ; VILA; NEVES, 2020; GIARDINO; JESUS, 2021).

Os achados deste estudo validam o papel do gerenciamento de casos, que é defendido pela *Case Management Society of America*, como uma ferramenta que os gerentes de caso atenderam às necessidades abrangentes de saúde de um indivíduo e de sua família por meio da comunicação e dos recursos disponíveis para promover a segurança do paciente, a qualidade do atendimento e os resultados econômicos (ARMOLD, 2019).

Por fim, o gerenciamento de caso utilizado em intervenções educativas para promover o uso do preservativo pode atender às necessidades dos sujeitos por meio de avaliação, coordenação e planejamento e assim possibilitar a aplicação de opções e serviços preventivos disponíveis, maximizando os cuidados de saúde (JOO; LIU, 2018).

6.2.3 Reforço comunitário

Um estudo incluído nesta revisão utilizou o Reforço Comunitário como embasamento para a intervenção aplicada, tendo conseguido aumentar o uso do preservativo entre os adolescentes em situação de rua. A abordagem foi projetada para ser uma intervenção familiar e não individual para ajudar um membro da família que usa substâncias e é resistente ao tratamento (WELSH *et al.*, 2019). Cita-se que essa abordagem foi adaptada, no estudo incluído nesta revisão sistemática, ao contexto da saúde sexual dos adolescentes em situação de rua, o que demonstra que embasamentos teóricos podem ser modificados e redesenhadados em IE (GODLEY *et al.*, 2017).

O Reforço Comunitário foi utilizado abordando três objetivos: I- envolver a pessoa resistente ao tratamento (uso do preservativo), II-reduzir o risco sexual (sexo

desprotegido) e III- melhorar o conhecimento e adesão ao tratamento. Estes objetivos, adaptados da concepção inicial, tornaram possível a intervenção.

Esta concepção inicial concentra-se na mudança de comportamento projetada para reduzir o uso nocivo de álcool enquanto ajuda os pacientes a trabalhar em direção a um estilo de vida abstinente (KIRBY *et al.*, 2017). Tais prerrogativas, adaptadas ao contexto de saúde sexual do adolescente em situação de rua, contaram ainda com sessões com apoio de pais/cuidador do adolescente em situação de rua.

Pesquisas já vem utilizando esta abordagem, como em estudos recentes com adultos demonstrando sua eficácia no tratamento da dependência de cocaína (HIGGINS *et al.*, 2003) e de opioides (BICKEL *et al.*, 2008). Tais dados ratificam que adaptações em modelos de intervenções são válidas e possíveis, como no estudo incluído nesta revisão.

Além destas adaptações em populações adultas, este modelo tem sido usado com sucesso em ambientes de cuidados continuados de tratamento ambulatorial e pós-residencial e validado através de ensaios clínicos randomizados para adolescentes (DENNIS; GODLEY *et al.*, 2004; GODLEY *et al.*, 2007; GODLEY *et al.*, 2014; HENDERSON *et al.*, 2016). Estes achados reafirmam que o modelo utilizado na intervenção sumarizada, também já vem sendo adaptado e direcionado a adolescentes, direcionado a comportamentos sexuais protetivos.

7. CONCLUSÕES

As intervenções educativas baseadas em aconselhamento, multiestratégias e reforço comunitário aumentam/estimulam o uso do preservativo entre adolescentes em situação de rua, sendo consideradas eficazes, com destaque para as baseadas em aconselhamento, que foram consideradas as mais eficazes.

Os achados narrativos e de sumarização, destacam que: o aconselhamento é uma estratégia psicoeducativa que deve ser realizada sob um modelo de atenção centrado no adolescente, integral e integrado, com abordagem biopsicossocial, sistêmica e construtivista, levando em consideração o curso da vida.

Os programas multiestratégia mostram-se opções promissoras ao empregar metodologias comportamentais e geracionais que tem potencial de gerar mudança de condutas e no estilo de vida (individualmente ou envolvendo a família). Por fim os achados desta revisão aferem também que as intervenções baseadas e/ou adaptadas em abordagem de Reforço Comunitário, configuram-se como um pacote abrangente de tratamento comportamental que se concentra no gerenciamento de comportamentos e tem como objetivo ajudar as pessoas a descobrir e adotar um estilo de vida prazeroso e saudável.

Ratifica-se que estudos de RS, complementados por metanálise são importantes porque agregam evidências de estudos menores em um único estudo, possibilitando maior precisão. A revisão aponta a eficácia das intervenções voltadas para o uso do preservativo em adolescentes em situação de rua, apesar do número de estudos ser incipiente para afirmar que são as mais recomendadas para este público e cenário.

Portanto, é altamente recomendável a condução de estudos qualitativos, de métodos mistos e/ou longitudinais (seguimento) para melhorar a tomada de decisão neste tema e público.

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ANEXOS

ANEXO A

Protocolo de pesquisa com as diretrizes para condução de Revisão Sistemática registrado na plataforma PROSPERO (Reino Unido – UK).

NIHR | National Institute for Health Research **PROSPERO**
International prospective register of systematic reviews

To enable PROSPERO to focus on COVID-19 submissions, this registration record has undergone basic automated checks for eligibility and is published exactly as submitted. PROSPERO has never provided peer review, and usual checking by the PROSPERO team does not endorse content. Therefore, automatically published records should be treated as any other PROSPERO registration. Further detail is provided [here](#).

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https://www.crd.york.ac.uk/prospero/display_record.php?ID=CRD42021266572

Review question
Can educational and/or health care interventions be effective for condom use among homeless adolescents and influence the reduction of the risk of acquiring HIV and other sexually transmitted infections?

Searches
The databases consulted will be: Medical Literature Analysis and Retrieval System Online (MEDLINE), Cochrane Central Register of Controlled Trials (CENTRAL), PsycINFO, Scopus, EMBASE, Web of Science, Cumulative Index to Nursing and Allied Health Literature (CINAHL), Literatura Latino-Americana e do Caribe em Ciências da Saúde (LILACS) and Base de dados em Enfermagem (BDENF)

Search strategy
https://www.crd.york.ac.uk/PROSPEROFILES/266572_STRATEGY_20210708.pdf

Types of study to be included
Randomized controlled trials (RCTs), with individual or group randomization. Non-randomized controlled clinical trials (non-RCTs), with individual or group level allocation. Controlled trials before and after with a minimum of two interventions and two control sites; observational cohort (with comparators) and case-control studies.

Condition or domain being studied
Interventions that promote health work as initiatives that improve the health conditions of people, groups or populations, expressing themselves through collective actions, operationalized and carried out by organizations/institutions, or individual actions, carried out by each individual. In this perspective, whether educational or focused on health care, they are related to health conditions, in addition to being linked to other factors, such as the reduction of economic costs with health and social security. It is important to consider particular those aimed at homeless adolescents, they should prioritize the identification of their health needs, a fact that makes those aimed at condom use in the context of sexual health as a foundation to prevent the transmission of STI's, being strategic for the control of the HIV/Aids epidemic and other STI's.

Participants/population
Inclusion: homeless adolescents (ages 10 to 19) – (WHO, 2021).
Exclusion: Studies in which participants are "young" with adolescent and adult populations , except where adolescent outcomes are stratified and reported separately from those of the general population.

Intervention(s), exposure(s)
Educational and health care interventions aimed at using condoms to reduce the risk of HIV infection and other sexually transmitted infections among homeless adolescents (runaways from home, shelter/hostel dwellers will also be included) that reports a primary result.

Comparator(s)/control
Studies whose educational and/or health care interventions aim at using condoms to reduce the risk of HIV infection and other sexually transmitted infections among homeless adolescents who report a primary

Page: 1 / 5

outcome.

No sexual health interventions or actions of any other nature (e.g. STI screening, availability of kits, vaccination campaigns)

Context

Health Health education. Health promotion. Condom use. HIV and other STIs. Homeless adolescents. Nursing.

Main outcome(s)

- Condom use
- Greater adherence to condom use
- Change (reduction) in HIV incidence
- Change (reduction) in the incidence of STIs

Measures of effect

odds ratios

Additional outcome(s)

- Change in risky sexual behavior
- Change in HIV prevention knowledge and skills
- Change in STI prevention knowledge and skills

Measures of effect

odds ratios

Data extraction (selection and coding)

For the selection of studies, two reviewers will independently search the databases with the support of Rayyan and Endnote software. To do so, they will make a general reading of the titles, abstracts and descriptor terms of the citations downloaded to identify potentially eligible studies for full reading. When there is disagreement on the eligibility of records, a third reviewer will be included.

Data extraction will be performed by two reviewers independently, who will use a standardized form. The following characteristics will be extracted from each included study: study and methodology information, participants, setting (also considering hostels/homes/shelters), intervention/comparator, outcomes, bias assessment data and quality of evidence.

Risk of bias (quality) assessment

The assessment of the risk of bias of the individual studies included will be performed by two reviewers who will independently assess the risk of bias of the studies, with a third reviewer in need of resolution in cases of severe discrepancies. For RCTs, the bias assessment tool – "Cochrane's Collaboration Tool" will be used. The Cochrane approach assesses the risk of bias in individual studies in six domains (ROB 2): sequence generation, allocation concealment, masking, incomplete outcome data, selective outcome reporting, and "other" potential biases.

For non - RCTs, the ROBINS I - instruments will be used for non-randomized studies involving intervention and the Newcastle-Ottawa Scale (NOS) for case-control and cohort studies. Studies that present high risk or do not comply with the proposed guidelines will be discontinued and disregarded for the purpose of this review.

Strategy for data synthesis

Data analysis and information synthesis will be carried out in two steps: First, in results combined with high heterogeneity, heterogeneity will be explored through subgroup analyzes by: sex, age, scenario, type of

study, educational intervention, care intervention in health and HIV/STI prevention. When relevant, sensitivity analyzes will be conducted to investigate the effect of excluding studies with a high risk of bias, studies with arbitrary inclusion criteria, and other methodological issues.

Subsequently, for the calculations and summary statistical presentations, the hazard ratio for dichotomous outcomes and the weighted mean difference for continuous outcomes will consider the 95% confidence interval (CI). Review Manager 5.4.1 software provided by the Cochrane Collaboration will be used for statistical analysis. I^2 (χ^2) statistics will be used to measure the heterogeneity between assays in each analysis. If substantial heterogeneity is identified ($I^2 > 45\%$), it will be explored by pre-specified subgroup analysis. If heterogeneity persists, sensitivity analyzes will be performed. The results will be presented separately and explanations for the observed heterogeneity will be proposed.

If possible, summary statistics will be performed using meta-analytic methods (minimum of 2 studies). If heterogeneity between studies is low to moderate ($I^2 \leq 45\%$), a fixed-effects model will be used. If it is high ($I^2 > 45\%$), a random effects model will be used. Where meta-analysis is impractical or inadequate, a narrative synthesis of the results will be made. If meta-analysis is performed on the proposed review, the potential for publication bias for the studies will be assessed using a funnel plot.

Analysis of subgroups or subsets

Subgroup analysis and investigation of heterogeneity. In results combined with high heterogeneity, we will explore heterogeneity through subgroup analyzes of the following:

- Sex
- Age
- Scenery
- Educational intervention
- Health care intervention
- HIV/STI Prevention's
- * Type of study

When relevant, sensitivity analyzes will be conducted to investigate the effect of excluding studies with a high risk of bias, studies with arbitrary inclusion criteria, and other methodological issues.

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Ms Kirley Kethellen Batista Mesquita. Universidade Federal do Ceará
Professor Regina Kelly Guimarães Campos. Universidade Federal do Ceará

Type and method of review

Intervention, Meta-analysis, Prevention, Systematic review

Anticipated or actual start date
04 October 2021**Anticipated completion date**
11 February 2022**Funding sources/sponsors**

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Conflicts of interest**Language**

English

Country

Brazil

Stage of review

Review Ongoing

Subject index terms status

Subject indexing assigned by CRD

Subject index terms

MeSH headings have not been applied to this record

Date of registration in PROSPERO

17 October 2021

Date of first submission

16 September 2021

Stage of review at time of this submission

The review has not started

| Stage | Started | Completed |
|---|---------|-----------|
| Preliminary searches | No | No |
| Piloting of the study selection process | No | No |
| Formal screening of search results against eligibility criteria | No | No |
| Data extraction | No | No |
| Risk of bias (quality) assessment | No | No |
| Data analysis | No | No |

The record owner confirms that the information they have supplied for this submission is accurate and complete and they understand that deliberate provision of inaccurate information or omission of data may be construed as scientific misconduct.

The record owner confirms that they will update the status of the review when it is completed and will add publication details in due course.

Versions

17 October 2021
17 October 2021

APÊNDICES

APÊNDICE A

Lista de artigos excluídos no processo de seleção dos estudos com auxílio do software Rayyan por desfecho errado, design de estudo errado e população errada.

1. 2013 CAEP/ACMU Scientific Abstracts, CAEP 2013. **Can. J. Emerg. Med.**, 15, p. S1, 2013 2013.
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APÊNDICE B

Instrumento de coleta de dados para extração das informações de interesse para síntese dos estudos.

FORMULÁRIO PARA EXTRAÇÃO DE DADOS

Avaliador: _____

Índice:

- Lado A – Informações editoriais
- Lado B – Informações de cenário e população
- Lado C – Informações sobre as redes de cenário
- Lado D – Informações metodológicas
- Lado E – Informações descritivas dos resultados
- Lado F – Informações dos resultados
- Lado G - Informações de cluster ou estratificação

Lado A - Informações editoriais

| CÓDIGO DO ARTIGO | Titulo | Autores | Ano | Periódico | Doi /link | Número e volume de publicação |
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Lado B - Informações de cenário e população

| CÓDIGO DO ARTIGO | País | Local do estudo (rua, abrigo, albergue) | Número de participantes | Sexo (proporção na amostra) | Faixa etária dos participantes |
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Lado C - Informações sobre as redes de apoio

| CÓDIGO DO ARTIGO | Identificação da instituição | Tipo de assistência prestada | Financiamento | Parcerias institucionais |
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Lado D - Informações metodológicas

| CÓDIGO DO ARTIGO | <i>Design do estudo</i> | Recrutamento | Randomização | Critérios de inclusão | Critérios de exclusão | Perdas de acompanhamento/desistências | Acompanhamento |
|------------------|-------------------------|--------------|--------------|-----------------------|-----------------------|---------------------------------------|----------------|
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Lado E - Informações descritivas dos resultados

| CÓDIGO DO ARTIGO | Descrição das intervenções | Descrição geral dos resultados |
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Lado F - Informações dos resultados

| CÓDIGO DO ARTIGO | Dados gerais da estatística (variáveis qualitativas, variáveis quantitativas) | Testes estatísticos empregados (correlação, regressão linear...) | Métodos de avaliação dos resultados | Denominadores/Inferências (resultados interpretáveis) Grupo controle/placebo |
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Lado G - Informações de cluster ou estratificação

| CÓDIGO DO ARTIGO | Dados gerais da estratificação (faixa etárias, idades, sexo ou outras condições) | Aspectos de comparabilidade Inter grupos | Implicações clínicas e patológicas | Critérios para avaliação de subgrupos |
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Período da extração: _____