

Young women born with HIV: communication of seropositivity to partners

Mulheres jovens que nasceram com HIV: comunicação da soropositividade aos parceiros

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ABSTRACT The objective was to understand the aspects involved in the communication of their own clinical condition to their partners by young women born with HIV. This is qualitative research, developed in a Specialized HIV Care Service in the southern region of Brazil with ten young people who were born with HIV, using the individual interview, from June 2017 to March 2018. An anchored psychosocial analysis was used within the Framework of Vulnerability and Human Rights. Two groups emerged: the first composed of young women who chose to communicate with their partners at the beginning of affective relationships; and the second, with the young women who postponed such communication. All of them experienced apprehensions and fears regarding the partner's reaction, thought about or adopted some strategies for communication, and reported situations of lesser involvement in HIV prevention behaviors by couples/partners. Care practices that dialogue with young women about the unique difficulties in their intersubjective contexts, crossed by structural social issues, are essential in order to support them in communicating their HIV status to their partners in as soon as possible, in adopting preventive strategies, and in accessing resources that protect their and their partners' sexual and reproductive health.

KEYWORDS HIV. Adolescent health. Sexual partners. Communication.

RESUMO *Objetivou-se compreender os aspectos envolvidos na comunicação da própria condição clínica aos parceiros por mulheres jovens que nasceram com HIV. Trata-se de pesquisa qualitativa, desenvolvida em Serviço de Assistência Especializada ao HIV na região sul do Brasil com dez jovens que nasceram com HIV, sendo empregada a entrevista individual, de junho de 2017 a março de 2018. Utilizou-se a análise psicossocial ancorada no Quadro da Vulnerabilidade e dos Direitos Humanos. Evidenciaram-se dois grupos: o primeiro, composto por jovens que optaram por comunicar sua condição clínica ao parceiro no início das relações afetivas; e o segundo, com as jovens que postergaram tal comunicação. Todas vivenciaram receios e medos da reação do parceiro, pensaram ou adotaram algumas estratégias para a comunicação e relataram situações de menor implicação nas condutas preventivas ao HIV pelos casais/parceiros. Conclui-se que são essenciais práticas de cuidado que dialoguem com as jovens sobre as dificuldades singulares em seus contextos intersubjetivos, atravessados por questões sociais estruturais a fim de apoiá-las na comunicação sobre a soropositividade aos parceiros em tempo mais oportuno possível, na adoção de estratégias preventivas e no acesso aos recursos que protejam a saúde sexual e reprodutiva delas e dos parceiros.*

PALAVRAS-CHAVE HIV. Saúde do adolescente. Parceiros sexuais. Comunicação.

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Introduction

Young women who were born with the Human Immunodeficiency Virus (HIV) have a health condition permeated by unique experiences in their life contexts. Among these, for example, are the loss of family members due to AIDS, the constant possibility of illness and/or death, efforts around adherence to treatment and the practice of safe sex and the communication of seropositivity to partners and people in their social life¹. Experiencing the challenges of a positive HIV serological condition in the context of affective-sexual relationships implies considerable efforts to build their projects for the future². The multiple scenarios, processes and challenges involving HIV encompass matters such as communicating their clinical condition to their partners, the 'serodifference', the (non) use of prevention strategies during sexual practices, the role of partners in managing everyday life and also sexual desires and reproductive plans³.

Safe sex practice concerns the negotiation and use of contraceptive methods between partners, especially serodifferent ones. Communicating this issue requires addressing sensitive matters, such as: knowledge of the partner's HIV status; the perception of the partner's loyalty; knowing about the transmission of the virus; and converging or diverging opinions regarding the intention to become pregnant⁴. In addition to that there are situations of stigma, prejudice and discrimination⁵ in the social relationships which result in a daily life of healthcare permeated by the fear of disclosing the diagnosis, usually shared only among people who are closer to the family¹. Faced with these challenges, it is essential to approach the reality of young women who were born with HIV regarding their serodifferent relationships when it comes to communicating their seropositivity to their partners and having preventive sexual practices.

From this perspective, the objective is to understand the aspects involved in young women who were born with HIV communicating their own clinical condition to their partners.

Material and methods

Qualitative survey carried out in a Specialized HIV Assistance Service in the southern region of Brazil. Potential study participants were young women aged 15 to 24 born with HIV and who became pregnant during their youth. The issue of pregnancy is justified by the fact that this article is part of a matrix study investigating the exercise of sexual and reproductive rights by this population. Young women who were no longer being followed up in the study setting (for having died, abandoned the study or moved to another city) were left out. All young women who met the criteria participated in the study; there were no refusals.

The ten participants were approached at the health service on the day of their appointment, by means of a semi-structured individual interview in a location at the service where there was privacy. The interviews were conducted by an experienced researcher, took place from June 2017 to March 2018, and lasted between 30 and 90 minutes, being audio-recorded and later transcribed. The topics addressed in the interviews were the experiences regarding the dimensions of life trajectories and the care received in health services involving the experience of pregnancy. The focus of this article specifically addresses aspects related to communicating their seropositivity to their partner(s), the father of their child(ren) and current partner.

Taking as a reference the Table of Vulnerability and Human Rights (TV&HR), a psychosocial analysis was made². The themes that are most expressive and recurrent on the trajectories of communication of those young ladies were identified and interpreted, allowing to understand how they can be exposed to different situations when it comes to communicating an HIV-positive status, those being situations that either provide conditions to communicate with awareness and having access to necessary resources or not. A synthesis of the participants' trajectories was made, exploring the aspects that possibly work as

protective factors or that increase exposure to ill HIV communication at the beginning of relationships, helping to understand the reasons for postponement.

Two groups of young women were highlighted, corresponding to two different communication situations with partners. The first group is made of six young women who chose to communicate at the beginning of their affective relationships with the partners who eventually became fathers of their children. The second group is made of four participants with greater difficulties in communicating with their partners and subsequent postponement, usually after exposure to sexual intercourse without regular use of condoms. In three situations, communication was postponed to the extent of taking place only after the birth of the couple's child. It is noteworthy that all of them stated that their partners were serodifferent, meaning, in other words, that they did not have a diagnosis of HIV infection, even after exposures related to unprotected sexual intercourse.

This division is important to understand the constituent elements of the individual, social and programmatic dimensions of the

TV&HR when reflecting on the trajectory of the young women and will be detailed in the results of this study.

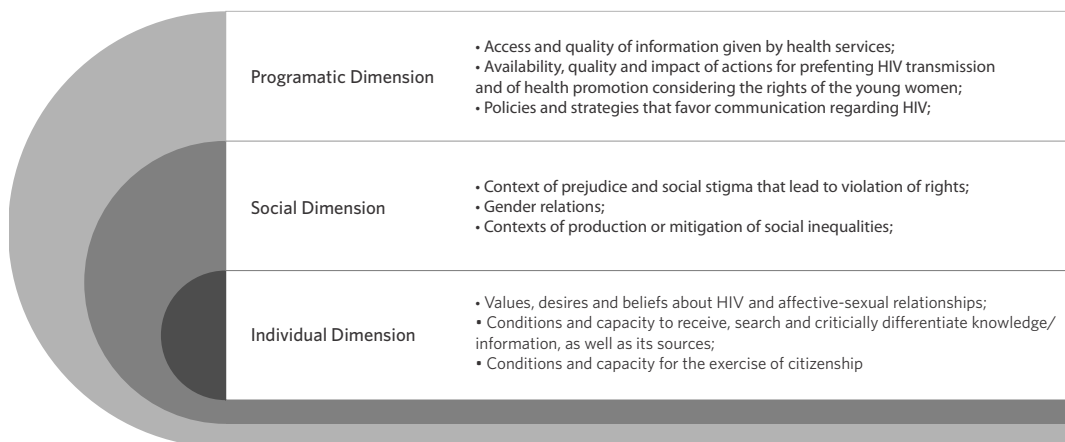
The ethical aspects foreseen in the development of research with human beings were respected, and the study was approved by the Research Ethics Committee under opinion numbers 1,844,848 and 1,912,645. The participants were identified by the letter 'P', for participants, and numbered according to their interview number.

Results

The ten participants were between 19 and 23 years of age, and only two had completed high school. Two young women reported that they had already used drugs as a result of living with partners who were users.

Next, the two groups of young women were approached in order to explore the elements of TV&HR in the trajectory of young women in HIV communication, and these are represented in *figure 1*. Although understood in each of its three dimensions, the interdependence between them is made clear.

Figure 1. Dimensions in the Vulnerability and Human Rights Table in the trajectory of HIV communication of young women



Source: Adapted from Ayres JR, Paiva V, Buchalla CM².

HIV communication to the partner at the beginning of the affective relationship

This group is composed of six young women, who are characterized in *table 1*. Regarding schooling, two stopped studying due to the ongoing

pregnancy, and two, due to the context of social stigma in relation to their clinical condition. All of them were supported by their partners or family members. Four remained in a stable relationship with the father of their child, and two were separated from their partner and were single at the time of the interview.

Table 1. Profile of young women who are part of the first group

| Young woman | Age | Education | Work | Raising | Religion | Marital status | Duration of relationship | Nº of pregnancies |
|-------------|-----|--------------------------------|------|------------------------|----------------------------|--------------------------|--------------------------|---------------------------------|
| P3 | 19 | Completed secondary education | No | Biological mother | Evangelical | Separated from companion | 5 years | Two (from the same partner) |
| P5 | 23 | Primary education | No | Relative | Catholic | Living with companion | 4 years | One |
| P7 | 22 | Incomplete primary education | No | Biological father | None | Living with companion | 3 years | Three (from different partners) |
| P8 | 23 | Complete Primary education | No | Relative | African-Brazilian Religion | Living with companion | 3 years | One |
| P9 | 22 | Incomplete secondary education | No | Sheltering institution | Evangelical | Separated from companion | 3 years | One |
| P10 | 21 | Incomplete secondary education | No | Sheltering institution | Evangelical | Living with companion | 3 years | One |

Source: Own elaboration.

In addition to experiencing everyday difficulties involving their own HIV seropositivity, young women need to communicate their clinical condition to their partners. As it is a delicate subject, this is a moment marked by fear of what the partner's reaction might be – and what they fear most and is most painful is rejection and break-up. All of them reported that they preferred to reveal it right at the beginning of the relationship, as soon as they felt that the relationship could become more 'serious' (dating), in an imaginary attempt to avoid possible suffering and disappointments resulting from that.

It was right in the beginning of our dating [before having intercourse], I already wanted to tell him

to not go on suffering. Can you imagine telling the truth and the person not wanting you any longer? You will suffer both because of the disease and because of your loss, two horrible things to cope with. (P3).

I was afraid of his reaction, and what if he doesn't want to go on? But those who really like someone, like the person the way she is. Because when we like someone, we don't guess what the person has [HIV], it is not written on our face. (P5).

I thought his reaction would be very different, but it was alright. Of course it brings fear as we ignore how the person will react, what he will think. But I told him before we had sex so as to avoid any problem later on. (P8).

If, on one hand, they recognize that it is necessary to protect the partner from the possibility of being infected by the virus, on the other hand disclosing their condition and being discriminated is an event that is possible and capable of making them suffer. In this process, the tendency is to tell about their condition once trust in the relationship is established, this being a fundamental element for exposing themselves to possible rejection.

Regarding the communication strategies used by this group, two situations were highlighted: the decision to have some prior preparation and the spontaneous dialogue taking place in the face of hidden signs. In the first situation (three participants), there was a prior preparation of the young women to conduct the conversation with their partner, generally based on the stability of the affective relationship and the need to reveal the fact before sexual intercourse. There was also the decision that was made by the young woman herself but counting on the help from third parties for better communication given the difficulties found.

I decided to tell as it was becoming unbearable to hide any longer, even more so because if we decided to have sex, he would probably find out later on and can you imagine that? [...] So I told him. I decided to tell. (P3).

I told him before we went on with the relationship and eventually had sex, and my aunt helped me to tell him. I spoke and I explained everything. (P5).

He went to the shelter and the employees asked me if they could tell him that I was HIV-positive and I told them they could as I am not ashamed to tell. They talked with him separately and then they called me. (P10).

In the second situation (three participants), more spontaneous dialogues took place in the communication of seropositivity to serodifferent partners. These dialogues took place without prior preparations; however, it was

identified that they were preceded by veiled situations, which involved omitting information about one's own health (daily medication and regular medical consultations, hospitalizations or deaths of family members), until the actual occasion to report seropositivity arrived.

We started getting to know each other and dating. Then I got sick, I was hospitalized, I wasn't taking the medication properly [...] I wasn't prepared to talk, we were talking, he started asking about my mother and father, why they had died, so I said we had to talk. He asked me if I had it myself, and I said yes. (P8).

He had already seen that I was taking medicine, so he already knew. One day he came and asked: 'why do you take this medicine?', so I said: 'I have HIV, I'm HIV positive, I was born this way' (P9).

The partners' reactions to the communication of seropositivity in this group of participants were welcoming and this was revealed by them not making condemnatory judgments based on prejudice, and also by them taking the role of encouraging adherence to therapeutic and clinical care as in the case of taking medication correctly.

He took it lightly. [...] He said there was nothing to worry about and that it was a matter of both taking care. [...] He reminds me to take the medicine properly. (P7).

He started joining me in the medical appointments, he wanted to know every detail, wanted to take care of my taking the medicine. (P8).

He supports me and goes with me to the doctor's, he is the one who fetches my medicine. He doesn't have any prejudice. He said he loved and that he would remain by my side. (P10).

From the moment the HIV-positive status is communicated and the the partners react

in a welcoming and supportive manner, a development of preventive sexual behaviors is made evident. Mostly (four young women) by making regular use of condoms and willingly being tested for HIV in a periodical way. In this sense, one can see a young woman’s concern to avoid transmitting the infection to her partner.

He didn’t get it [HIV], as he was tested every three months at the health center. (P5).

I asked, so he could feel at ease to speak, if he had any doubt. [...] so he was tested [for HIV]. The result was negative. (P3).

I found it Ok [to be tested], so we could be sure that we were taking care of each other, and that I hadn’t passed it on to him. (P9).

Postponement of HIV communication to the partner

This group is made of four young women, who are characterized in *table 2*. It has a trend of lower educational level, with reports of interruption of studies due to the pregnancy in progress and/or need to work, this Leading to lack of professional training/employability. The young woman who experienced two pregnancies with different partners reported that the first partner found out about her seropositivity only after the birth of the child resulting from a short-term relationship. The second child came from the stable relationship she was in at the time of the interview, and with prior communication of HIV serology.

Table 2. Profile of young women who are part of the second group

| Young woman | Age | Education | Work | Raising | Religion | Marital status | Duration of relationship | Pregnancies |
|-------------|-----|-----------------------------|--------------------|-------------------------------------|----------------------------|-------------------------------------------|--------------------------|-------------------------------|
| P1 | 19 | Incomplete secondary school | No | Biological mother | African-Brazilian religion | Separada do companheiro | 2 years | One |
| P2 | 19 | Incomplete primary school | Yes, recycling | Orphan, unhealthy housing situation | None | Com companheiro (em situação presidiária) | 3 years | One |
| P4 | 19 | Complete primary school | No | Biological mother | Evangelical | Convive com companheiro | 2 years | Two (from different partners) |
| P6 | 22 | Incomplete secondary school | Yes, and practices | Orphan, raised by relative | None | Convive com companheiro | 5 years | One |

Source: Own elaboration.

The four young women communicated their clinical condition to their partners after sexual intercourse and confirmation of the pregnancy, with one young woman sharing her seropositive condition during the course of her pregnancy, and three young women doing it only after the birth of their children. The difficulty in communicating the clinical condition of HIV seropositivity in this group

is substantiated by the fear of situations of stigma, either by the partner or by his family, based on the judgment of ‘guilt’. This denotes the suffering that this situation causes in the lives of these young women, resulting in the postponement of this disclosure.

It’s very difficult for you to be able to convince a person that you date, or that you might even marry, to try to

explain to him that it's not your fault, it is something that people don't see, but that happens. [...] [after communicating seropositivity] I kept on showing him that I didn't want him to get it either [HIV]. (P1).

Faced with the difficulty of communicating HIV seropositivity to the partner, there is a delay and the need for third parties (doctor and mother-in-law) to mediate/delegate the communication to the partner (as in the case of two of these young women). It is noteworthy that one of these four participants found out about her own positive serological condition during the prenatal period (despite it being vertically transmitted), and that the doctor helped her to communicate this to her partner. The others were previously aware of their serological status, and all were in stable relationships (dating) with their partners when they found out about their pregnancy. Two young women themselves disclosed their clinical condition to their partners after the birth of their children, one due to the partner's situation in a prison institution and the other one due to not being in a relationship with the child's father any longer.

I thought the best way for me to tell it would be first to his mother [...] her reaction was very spontaneous, she cried, she got very sad. [...] Then she talked to him [communicated the seropositive diagnosis of the young woman]. (P1).

The doctor [...] asked if I wanted to tell it later [...] he [boyfriend] came in and I told him right away [at the prenatal consultation]. (P6).

Of these four young women, two reported that they suffered pressure/embarrassment from health professionals to communicate with their partners, especially because they were having unprotected sex, which led to pregnancy.

They [the health professionals] are not willing to release a patient without the father becoming aware of what is happening [HIV]. As I could walk out of there and never tell him again. [...] they

started to put pressure on me [...] and I went into postpartum depression. (P1).

They [the health professionals] started to put pressure on me, you know, and they went to my house. [...] Well, I was really wrong, I stopped coming here [at the health service], and now this is really being a nuisance [guardianship council]. (P2).

In this group, there were reports by the participants of reactions of surprise, hostility and/or insecurity from the partners, due to the breach of trust and/or because they felt threatened by a possible infection, implying efforts by the young women living with HIV to preserve their love relationship or finally break it up. It is evident that communication after sexual intercourse and the consequent possibility of infection by the partner have an effect that corroborates the difficulty of acceptance and continuity of the relationship by the serodifferent partner. These three young women who experienced negative reactions from their partners only communicated their seropositivity to them after finding out they were pregnant, even though they had been previously aware of their infection. Among these three, only one maintained the relationship with her partner. The other two ended up separating from their partners, with whom they kept in touch due to the child they had in common.

He was in a state of shock [...] I was very afraid of what his reaction would be as soon as he came out of it. (P1).

He said: 'oh you should have told me, you should have let me know', but he accepted it [...]. (P2).

He was terrified, he thought he had caught it too. (P4).

Given the communication postponement, it is noticed that some of the couples were prone to adopt preventive sexual behavior. However,

even after partners becoming aware, in the accounts of some of the young women there is evidence of abandonment or inconsistency in the use of condoms, as well as the acknowledgement of the need to be tested for HIV.

For the time I remained with him, I didn't use any [condoms in sexual intercourse]. [...] I think I waited for an initiative of his that never was. (P1).

He even has to be tested [for HIV] again, as we were only tested when I found out I was pregnant and never again. (P4).

In addition to this, according to the young women's reports, especially P2, there is the impression of there being a very incipient personal recognition by most partners of the real risk of HIV infection through unprotected intercourse and/or use of drugs. It was noticed that the partner showed no interest in having an evaluation and a diagnosis.

He [the partner] never comes to the hospital, he is not willing to know. [...] I bet that when he feels unwell, he goes straight to taking his medicine. He couldn't care less. He is quite shameless. If he came here, it would be easier, he would have an appointment, get his meds, it would be better. (P2).

Discussion

The process of communicating the HIV seropositive condition to affective and sexual partners is a delicate subject and permeated by dilemmas for young women born with HIV. By deciding to disclose their diagnosis, the young women free themselves from the burden of remaining silent, but live in fear of prejudice and stigma. Dealing with the possibility of losing a partner in the context of an affective relationship involves having to deal psychologically with the representation of many risks, insecurities and, in some contexts, threats, not only from the potential of transmitting HIV,

but especially from the possibility of rejection⁶.

A more accurate analysis of vulnerability² – to understand in depth the context of the difficulties of having safe sex more regularly in those relationships and thus offering care – must take into account the specific context of a steady relationship among young women with plans for the future, affection and yearnings related to reproduction and family Building, apart from the typical fear of discovering oneself infected by the HIV. It is important that services welcome young women and their partners when, upon recognizing how being infected can affect their reproductive plans, they seek guidance and resources for safely discontinuing condom use and adopting appropriate preventive measures to guarantee reproductive rights.

In the intersubjectivity of those young women, in the daily life scenes described, one can notice conflicting values, desires and beliefs, all this pervaded by a cultural scenario of systematic stigma and discrimination², sometimes related to lack of access to other social rights. If, on one hand, young women recognize the need to protect their partners from the possibility of becoming infected with the virus, especially when they are unaware of their seropositive status, on the other hand, the fear of being discriminated against and emotionally rejected when disclosing their condition anticipates suffering and makes communication with the partner difficult. A study carried out in South Africa found out that the non-disclosure of the clinical condition of HIV among sexual partners is associated with the stigma and discrimination of having the virus, and is directly related to risk behaviors for HIV transmission⁷. The fear of abandonment arising from prejudice and the certainty that the secret when entrusted to the other one may not be kept results in the tendency to disclose only when there is an established trust in the relationship. Knowing the best moment and deciding who to trust are questions that come along with anguish and restlessness⁸.

In this way, the young women transit between the desire to share their secret, the fear of rejection and the guilt for hiding the truth. Whether by conscious decision, or in a poorly thought-out behavior of keeping silent about seropositivity, what becomes evident are situations of difficulty and tension in relation to disclosing their diagnosis, because doing so has the meaning of revealing oneself, and this is not simple⁹. From the accounts of the young women in this study about the fear of imminent rejection, a metaphor can be suggested: that, in their view, there might be a 'domino effect' after the communication of HIV seropositivity, with several subsequent losses related to it. Thus, positive adaptation in a context of difficulty can provide a better quality of life in relation to the experience of stigma and social exclusion in the face of HIV infection¹⁰.

The group of young women who postponed communication, exposing the partner to the risk of infection in sexual intercourse without a condom, made a transgression, considering that the partner had the right to know. Thus, non-disclosure is perceived as a harmful attitude to the other one¹. Among the young women who postponed communicating with their partner, there is evidence of a lower level of education and of knowledge for preventive behavior, which seems to be the case of those who, although aware of their clinical condition, did not communicate as they should.

Knowledge, as a psychosocial construct, is an important predictor of vulnerability to HIV infection, as people with less knowledge about the means of transmission of the virus tend to engage in higher risk sexual practices¹⁰.

Communicating HIV already at the beginning of relationships, as was the case with most participants, corroborates a study performed with Canadian adolescents pointing out that women tend to be more concerned and understand that sexual intercourse is not conceivable unless their partners are informed about their serological status⁶. A study performed in Ethiopia showed that knowing

that the partner has the virus leads to higher use of condoms, more social support and a better relationship with the partner¹¹. It is therefore considered that the shared diagnosis can have a better relationship as an outcome.

For such, the concern these women have also results, at least to an extent, from affective-sexual relationships marked by gender regulatory norms and HIV/Aids stigma processes demonstrating violation of human rights². Women imprisoned by a control society, caught up in relations of power inequality due to the male dominant mindset ruling over their bodies and minds¹², need support in order to better adhere to the necessary preventive measures that avoid HIV transmission.

To prevent viral transmission, it is essential to have these young women welcomed, especially by health services, and to build among those involved the notion of co-responsibility. This can be done by means of creating spaces for reflecting, elaborating and planning and by taking into account, besides the clinical aspects, the life stories and plans and the meanings of the relationships in progress, which is to say the subjective dimensions² involved in communicating the diagnosis as well as the social and psychological impacts related to stigma and prejudice still pervading HIV.

It is understood that the process of communication requires development and that it requires the young woman becoming more inventive and able to improvise solutions⁹. In the strategies for communicating HIV seropositivity to the partner reported by the participants, it was possible to perceive initiatives that covertly demonstrate efforts, through verbal/non-verbal communication or with the support from third parties (family members or health professionals). To help in this process, a study points out that professionals generally choose actions centered on the patient, the most common of them being: threat (attempt at coercion, announcing possible sanctions and legal and judicial implications of non-disclosure); campaigning (investment in speeches

to dissuade and convince); advice (interaction for interpersonal effort); complicity (offering to participate/carry out the communication process); and the discussion group (enriching the argumentative repertoire by explaining third-party experiences)¹³.

The communication process is not simple, it usually implies a previous phase in which, in terms of the psychological process, there is a significant emotional-cognitive mobilization on how and when to reveal seropositivity, demanding a certain preparation and personal decision-making¹. The proposal of using strategies investing in constructing (and reconstructing) argument repertoires widens the possibility of dialogue in the communication with partners¹³. In that sense, the notion of care² refers to the importance of conciliating the commitment to being technically successful in health with the patient's existential horizon, taking into account the subjective aspects and the social contexts, as well as the previous rejection and abandonment experiences⁹, so as to reach effective practices in health. HIV-related stigma and discrimination, as psychosocial constructs, are associated with not disclosing HIV status to sexual partners; and non-disclosure is closely associated with risk behaviors for HIV transmission.

Fortunately, for some of the young women in their relationships, the disclosure produced feelings of affection, solidarity and renewal of the concepts of both living and living together. A study points out that this positive experience strengthens marital arrangements leading to more complicity in the relationship¹⁴, with the HIV seropositivity becoming a 'marital secret' in the attempt to protect the partner from social retaliations and strengthen the bond between the couple.

However, the guilty feeling of having HIV was experienced by most of the participants, especially when the young women assumed that there was someone to blame for their infection via vertical transmission. In addition, the fear of a lawsuit due to infecting someone else reveals the magnitude of the strongly

disseminated social meaning: that, in fact, there is someone to blame, even if potentially, in the case of the risk of HIV transmission to the partner. In Brazil, both transmission and exposure to HIV are crimes that can be framed in arts. 130 and 131 of the Penal Code¹⁵.

A study that analyzed the criminalization of HIV transmission in Brazil points out that progress has been made, expressed by the jurisprudence of the Federal Supreme Court, regarding the transmission of the virus as the transmission of a serious illness, and not as an attempted homicide; and by defining the disease as a chronic condition, and not as a 'death sentence'. It appears that, legally, the communication of seropositivity to the sexual partner is central in the judgment about the responsibility for the transmission of HIV. However, the same study points to some setbacks, such as the attempt to implement laws that criminalize the transmission of the virus with severe penalties that disregard current prevention and treatment technologies and reinforce stigmatization, reiterating fear¹⁶.

Thus, the moral condemnation of people living with HIV persists. There is still a need to foster debate in society about the effects of criminalizing HIV transmission in light of the current epidemic scenario in Brazil and in the world, which tend to keep the population away from testing and, consequently, from treatment, thus affecting health public¹⁶.

From the point of view of HIV prevention, the timely diagnosis, in theory, would increase the responsibility and care through the use of condoms to protect the partners⁸. However, this is not easily put into practice by the young female participants, as a result of postponing communication with their partners or for not understanding it as exposure to HIV. A study points out that couples tend to abandon condoms even when aware of the serological status of their partners¹⁶, by establishing a pact to accept the risks implied or by being passive to the partner's will³.

This way, the programmatic dimension is also implied² in the elements making up the

context of these young women in what refers to the importance of the continuous follow-up of the health of their partners, for the promotion of guidance on preventive behavior and the offering of HIV testing, aiming at an early diagnosis for starting treatment in case of infection. It stresses the need to disseminate the offering of tests in primary care and specialized services in an impersonal and less generic way, minimizing discriminatory or even trivializing perceptions, but guided by counseling before and after testing that contributes to the maintenance of personal care¹⁷.

Counseling is recommended, evidencing the concept of immunological window and the need to repeat the test due to exposure, which seems not to have been discussed with the young woman participants, neither with them and their partners together. This suggests an increase in vulnerability to sex without using a condom, which, on an individual level, is revealed as a 'deliberate avoidance' or 'naive avoidance' by the partners of thinking realistically about the possible harmful implications for their health in case of infection – perhaps as a way of coping with excessive fear of an HIV-positive result^{18,19}.

A study identified individual, relational and systemic factors that affect men's decision to accept taking the test, such as the lack of involvement in monitoring health care, inadequate appointment times and fear of stigma²⁰. There is lack of guidance by the health services and of co-responsibility by these young women, making evident the individual and programmatic dimensions of the production of vulnerability², with consequences in the realm of the exercise of sexual and reproductive rights.

The logic of rational and prescriptive prevention, based only on the recommendation of condom use, needs to be transformed, incorporating a horizontal dialogue between health professionals and users, encompassing strategies that combine different types of prevention practices, reducing vulnerability to the potential exposure to HIV, even for those

who have difficulty using condoms. Thus, intersubjective and social contexts could be configured to generate more assertive and effective attitudes and behaviors in choosing personal preventive strategies^{13,21}.

Final considerations

This study allowed to understand one of the central difficulties in the life trajectories of young women living with HIV: communicating their clinical condition to their partners, considering what this represents in terms of social and personal meanings linked to the affective-marital field. It was noticed that this communication is strongly permeated by fear of the partner's reactions, generally imagined as hostile and discriminatory, which results, in some cases, in postponing the conversation. There is a belief that there will be a time when the relationship will be more mature and the bonds more solid, which reduces the feeling of threat of rejection and termination. In this scenario, these concerns, fears and this concealment of information compete with the construction of experiences protected from risks, that is, it contributes to the increase of vulnerabilities in sexual and reproductive health, even though some young women are concerned about not transmitting the virus.

As communication strategies, both the decision to have some previous preparation and the spontaneity of the dialogue were revealed. Other young women felt safer to communicate with the help of third parties (whether family members or professionals). The partners' reactions, for the most part, were of acceptance/welcoming, even making up the incentive for their commitment to health care. This points to the importance, in the care encounters, of addressing the feelings and thoughts of a fatalistic nature around the threats of rejection and separation. However, those who postponed communication for too long, doing it only after sexual intercourse and pregnancy, even in stable relationships, had more difficulties

in maintaining the relationship in the long term, after the ‘breach of trust’ caused by them omitting their condition.

Amid these challenging and potentially stressful experiences of living with HIV, there are also difficulties in the couple accepting more assertively the preventive behavior, as well as well as in having the partners being tested for HIV, thus making evident the ‘blind spots’ in guidance and advice given to couples by health services.

By transcending the approach of individual conduct, it is possible to incorporate and articulate, in a dynamic and integrated way, the dimensions of QL&DH that contribute to shaping communication in relation to HIV in the context of young women, as opposed to discourses that threaten ethical and human rights principles. Thus, it is clear that it is necessary to invest in psychoeducational support in HIV care, aimed especially at young women, for their personal development towards health practices and repertoires capable of overcoming challenges posed in certain intersubjective

and social contexts that increase risks and vulnerabilities in health. This support by the services can increase attitudes and behaviors of greater autonomy, assertiveness, based on the domain of knowledge and information, especially if this takes place in a timely manner by valuing subjectivity and active listening in a sensitive, solidary way, and being done continuously in the work of the teams of health.

Collaborators

Silva CB (0000-0002-1254-019X)*, Motta MGC (0000-0002-4335-1084)* and Bellenzani R (0000-0002-7211-6518)* contributed to the conception and outline of the study, the analysis and interpretation of results and the critical review of the content of the manuscript. Brum CN (0000-0002-2970-1906)* and Ribeiro AC (0000-0003-3575-2555)* contributed to the writing and critical review of the content of the manuscript. ■

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