

Perceptions on the adherence to treatment and psychological variables of HIV-seropositive pregnant women to HIV/AIDS

Percepções sobre adesão ao tratamento e variáveis psicológicas de gestantes soropositivas para o HIV/AIDS

Percepciones sobre la adhesión al tratamiento y las variables psicológicas de las gestantes seropositivas para el VIH/SIDA

Received: 28/01/2020

Approved: 15/06/2020

Published: 01/07/2020

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This is a qualitative study that had the goal to describe the perception of pregnant women with HIV/AIDS about the diagnosis, adherence to treatment and psychological variables in regards of the disease. The research took place between May and November of 2018. For this study, we surveyed pregnant women going through prenatal care in a tertiary-level university hospital, in the interior of the state of São Paulo. We applied an structured interview script, the Hospital Anxiety and Depression Scale and Ways of Coping with Problems Scale. Four categories were created: *HIV Diagnosis, Knowledge about HIV, Treatment and Adherence to Drug Treatment*. It found that the women's perception is of a diagnosis with no possibility of cure, but with a perspective of quality of life for them and fetus/newborn. Three participants showed emotional vulnerability with symptoms of anxiety and/or depression, and all of them showed coping focused on religion. The results raised an alarm to healthcare teams about the need for support and multidisciplinary monitoring that favors psychosocial support to the pregnant women, in order to help to change of maintain adherence behaviors.

Descriptors: Pregnancy, high-risk; HIV; Treatment adherence and compliance; Infectious disease transmission, vertical.

Trata-se de uma pesquisa qualitativa, realizada de maio a novembro de 2018, que teve como objetivo descrever a percepção de gestantes com HIV/AIDS sobre o diagnóstico, adesão ao tratamento e variáveis psicológicas frente à doença. Participaram desse estudo cinco gestantes em acompanhamento pré-natal em um hospital universitário, de nível terciário, do interior do Estado de São Paulo. Foram aplicados roteiro de entrevista semiestruturado, as Escalas Hospitalar de Ansiedade e Depressão e Modos de Enfrentamento de Problemas. Quatro categorias emergiram: *Diagnóstico do HIV, Conhecimento sobre HIV, Tratamento e Adesão ao Tratamento Medicamentoso*. Verificou-se que a percepção é de um diagnóstico sem a possibilidade de cura, mas com perspectiva de qualidade de vida para elas e para o feto/neonato. Três participantes manifestaram vulnerabilidade emocional, com sintomas de ansiedade e/ou depressão e todas mostraram o enfrentamento focalizado na religiosidade. Os resultados suscitam um alerta às equipes de saúde sobre a necessidade de apoio e acompanhamento multidisciplinar que possa favorecer o suporte psicossocial às gestantes, de maneira a auxiliar na mudança ou manutenção de comportamentos de adesão.

Descritores: Gravidez de alto risco; HIV; Cooperação e adesão ao tratamento; Transmissão vertical de doença infecciosa.

Se trata de una encuesta cualitativa, realizada entre mayo y noviembre de 2018, que tuvo por objeto describir la percepción de las mujeres embarazadas con VIH/SIDA sobre el diagnóstico, la adherencia al tratamiento y las variables psicológicas ante la enfermedad. Participaron en este estudio cinco mujeres embarazadas que recibían atención prenatal en un hospital universitario de nivel terciario del interior del Estado de São Paulo. Se aplicó un guion de entrevista semiestruturado, las Escalas Hospitalarias de Ansiedad y Depresión y Maneras de Enfrentamiento de Problemas. Surgieron cuatro categorías: *Diagnóstico del VIH, conocimiento sobre el VIH, Tratamiento y Adherencia al Tratamiento con Medicamentos*. Se encontró que la percepción es de un diagnóstico sin posibilidad de cura, pero con una perspectiva de calidad de vida para ellas y el feto/neonato. Tres participantes manifestaron vulnerabilidad emocional, con síntomas de ansiedad y/o depresión y todas mostraron un enfrentamiento centrado en la religión. Los resultados alertan a los equipos de salud sobre la necesidad de un apoyo y seguimiento multidisciplinario que pueda favorecer el apoyo psicossocial a las mujeres embarazadas, para ayudar a cambiar o mantener los comportamientos de adherencia.

Descriptorios: Embarazo de alto riesgo; VIH; Cumplimiento y adherencia al tratamiento; Transmisión vertical de enfermedad infecciosa.

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INTRODUCTION

The Acquired Immunodeficiency Syndrome (AIDS) is a chronic infectious disease, caused by the Human Immunodeficiency Virus (HIV). From 2007 to June 2017, 194,217 new cases of HIV infection in Brazil were notified to the Information System for Notifiable Diseases (*Sistema de Informação de Agravos de Notificação - SINAN*). In the same period of time, the number of cases reported by gender was 131,969 (67.9%) cases in men, and 62,198 (32.1%) cases in women¹. The number of reported cases in men is still greater than in women, but HIV cases in women are growing at an alarming rate. With the changes in the epidemiological profile of HIV/AIDS, individuals with the virus started to live with the infection, experiencing different stages of their development in the presence of the virus. In the case of women of childbearing age, the experience of motherhood and the possibility of vertical transmission of the virus from mother to fetus stand out². This vertical transmission route is responsible for more than 90% of pediatric infection cases in Brazil. Between 2000 to June 2017, 108,134 cases of pregnant women infected with HIV¹ were notified.

Due to governmental actions, the occurrence of vertical transmission has been decreasing considerably in recent years, especially with high-risk pregnant women with HIV in prenatal care³. When no prophylactic interventions are performed during pregnancy, or when there is no adherence to prophylaxis for vertical HIV transmission, transmission of the virus via mother-fetus occurs in about 25% of pregnancies of infected women. However, it is possible to obtain better results in terms of controlling maternal infection and prophylaxis of transmission of the virus in cases where the mother follows all recommended treatments, with levels below 2%.

Some of the recommended treatments are: the use of antiretrovirals medications from the 14th week of pregnancy; going to appointments with an obstetrician and general practitioner/infectologist; going through prenatal exams; having an elective cesarean delivery in pregnant women with high or unknown viral loads, or by obstetric indication; not breastfeeding; use of the lactation-inhibiting drug in the postpartum period; administration of Zidovudine syrup (AZT) to the baby for six weeks at the recommended dosage, among other actions⁴. Therefore, adherence to antiretroviral treatment during the pregnancy period - and the consequent decrease in viral load - is the measure of greatest result for the prevention of pediatric infection⁵.

The term "adherence to treatment" transcends the simple ingestion of medications, being seen as a joint activity in which the patient not only obeys medical guidelines, but understands, agrees and follows the prescription established by their doctor. A therapeutic alliance between doctor and patient is necessary for an adequate adherence to treatment, in which not only the specific responsibility of each person in the process is recognized, but also of everyone who is involved (directly or indirectly) in the treatment⁶. Strict adherence to antiretrovirals medication is essential, since the main risk factor associated with maternal-infant transmission of HIV is the elevated maternal viral load. The late diagnosis of HIV infection during pregnancy, the low adherence to technical recommendations by health services and the quality of care, especially in regions with less healthcare services coverage and less access to healthcare networks, are the main factors that hinder the national reduction in vertical HIV transmission rates⁴.

A study carried out to understand the experiences and factors that interfere with adherence to antiretroviral therapy for pregnant women with HIV/AIDS showed that, for pregnant women to be able to meet health recommendations more effectively, it is necessary that they have a space in which anxiety, fear and also hope and motivation (which mix with so many other feelings) inherent to the maternity process can be expressed and worked on. This situation points to the need to develop strategies to assist in adhering to the treatment of HIV-positive pregnant women⁷.

Welcoming actions, group activities and actively seeking the absentees are strategies that, by enabling the inclusion of pregnant women in prenatal services and bringing them closer to the team, can prevent abandonment of treatment and improve the adherence of pregnant women with HIV⁸.

Considering what was said above, the present study aims to describe the perception of pregnant women with HIV/AIDS on the diagnosis, adherence to treatment and psychological variables in regards of the disease.

METHOD

The study was carried out at the High Risk Pregnancy Clinic - Infectious Diseases in Gynecology and Obstetrics (*Ambulatório de Geração de Alto Risco - Moléstias Infectocontagiosas em Ginecologia e Obstetrícia* - AMIGO) of a tertiary-level university hospital, located in a city in the interior of the state of São Paulo. It is one of the outpatient clinics of the High-Risk Pregnancy Sector of the Department of Gynecology and Obstetrics, composed of a multidisciplinary team that includes professionals in obstetrics, infectious diseases, psychology, psychiatry, social work and nursing. It offers treatment and comprehensive prenatal care to pregnant women diagnosed with diseases that can infect the fetus, such as HIV, toxoplasmosis, syphilis, among others, in addition to patients suffering from drug addiction and psychiatric disorders.

Five HIV-positive pregnant women over the age of 18 took part in this study. They had performed at least two previous visits with the prenatal medical team, and signed the Free and Clarified Consent Form (FCCF), thus accepting that the data collected could be used in this research. The volunteers were informed about the research project, its objectives, procedures, risks and benefits, the confidentiality of their identity and that, at any time, they could withdraw from the research without any harm to their treatment at the hospital. This study was approved by the Research Ethics Committee, under no. 2,667,078, in compliance with Resolution 466, of December 12, 2012, by the National Health Council for research with human beings.

Those who could not participate in this study include: Pregnant women with other types of infections; those who had any apparent or reported cognitive deficit, those who made it impossible to perform the interview and complete the scales; those who refused to participate in the research; or in cases when there was a need for assistance directed to emergency demand.

We made the invitations to participate in the study in the patients' first psychological care appointment. The psychology team appointments were carried out on the same date as the AMIGO prenatal appointments, in order to optimize the patient's time and offer multidisciplinary care. All HIV-positive pregnant women who attended the outpatient clinic from May to November of 2018 were invited.

For data collection, we used: a Semi-Structured Interview Guide, composed of socio-demographic data, life habits, clinical data and treatment adherence, the patient's perception of their relationship with the health team, cognitive aspects, history of mental health and perception of social support; the Hospital Anxiety and Depression Scale (HAD); and the Ways of Coping with Problems Scale (WCPS). We applied these tools in two meetings, the first being the Interview Guide and, in the second meeting, the HAD and WCPS scales. Data collection was performed, individually, in an available room, where the multidisciplinary team performs the appointments, and it lasted approximately 50 minutes.

WCPS is a psychological assessment tool, and adapted for the Brazilian population by Gimenes and Queiroz and validated by Seidl, Tróccoli and Zannon. It assesses which types of coping strategies are most used by an individual when exposed to a problem^{9,10}. For each one of the 45 questions, the score ranges from 1 to 5 and then the mean of the answer is calculated. Strategies and respective issues that define them are: Coping focused on the problem, Coping focused on emotion, Coping based on religious practices and fantasy thinking and Coping based on search for social support^{9,10}.

The HAD scale, proposed by Zigmond and Snaith in 1983 and validated in Brazil by Botega and collaborators, consists of 14 items, seven of which refer to the evaluation of anxiety (HAD-A) and seven to the evaluation of depression (HAD- D)^{11,12}. Each item can be scored from 0 to 3, making up a maximum score of 21 points for each scale. Thus, the frequency of anxiety disorder and depressive disorder is obtained from the responses to the HAD items. The following recommended cut-off points have been adopted: for both HAD-A and HAD-D, scores from 0 to 8 that indicate that the patient has none of these conditions, while scores greater than or equal to 9 are translated as anxiety or as depression, respectively^{11,12}.

For data analysis, we used quantitative and qualitative approaches. The HADS and WCPS data were analyzed quantitatively, according to the rules of each instrument. The qualitative data obtained in the interview script were analyzed using the Thematic Content Analysis¹³.

Content analysis is characterized by a set of communication analysis techniques, which uses systematic and objective procedures to describe the content of messages that allow the inference of knowledge related to the conditions of production (or, possibly, reception), this inference may occur to quantitative indicators or not. The technique of content analysis refers to the study of both the content in figures of speech, ellipsis, between the lines, and the manifests¹³.

RESULTS

In regards to the socio-demographic profile of the five pregnant women surveyed: their average age was 31 years old, with a minimum age of 21 years and a maximum age of 42 years; at the time of this study, three lived in the city of Ribeirão Preto and two lived in other cities in the interior of the state of São Paulo; two pregnant women reported being legally married, one was in a stable relationship and cohabiting with her partner and two declared themselves single; three had finished high school and two had not finished elementary school; three were Catholics and two were Evangelicals; one performed activities solely based on the care of her own home, one was unemployed, and three were employed. Only one participant had no income and the average income of the others was R \$ 1,140.00, according to Table 1.

Table 1. Sociodemographical characteristics of the pregnant women cared for in a general hospital. Ribeirão Preto, May to November of 2018.

Patients	Age	Origin	Marital status	Educational level	Profession	Religion	Income
P1	21	Ribeirão Preto	Cohabiting with partner	High School (complete)	Housewife	Evangelical	No income
P2	42	Ribeirão Preto	Married	High School (complete)	Nursery Worker	Catholic	R\$ 1100,00
P3	30	São Carlos	Single	Elementary School (incomplete)	Unemployed	Catholic	R\$ 600,00
P4	34	Ribeirão Preto	Single	Elementary School (incomplete)	Cleaning assistant	Evangelical	R\$ 2000,00
P5	28	Brodowski	Married	High School (complete)	Seamstress	Catholic	R\$ 2000,00

The participants had the following perceptions of their clinical data and adherence to treatment: a) average gestational age at the 1st psychological appointment, 30 weeks and 3 days; b) all patients have already had pregnancies other than the current one; c) only one patient replied that she planned the current pregnancy; d) most of them had other comorbidities in addition to the HIV diagnosis (4), with only one participant having no other comorbidities; e) all had an understanding of their clinical condition; f) three understood all stages of their treatment and two partially understood them; g) all had positive and realistic expectations of recovery/cure; h) two patients had no complaints from the team about their adherence, but the others did (Table 2).

Table 2. Clinical data of pregnant women cared for in a general hospital. Ribeirão Preto. May to November of 2018.

Patients	Gestational age on 1 st appointment	Number of pregnancies	Planned pregnancy	Comorbidities	Perception Clinical condition	Perception Treatment	Expectations of recovery and/or cure	Complains from team about adherence
P1	27w and 4d	2	No	None	Yes	Total	Positive and realistic	No
P2	18w and 6d	4	No	Increased risk of trisomies	Yes	Total	Positive and realistic	Yes
P3	34w	9	Yes	Anemia and insufficient weight gain	Yes	Total	Positive and realistic	Yes
P4	38w	7	No	Overweight	Yes	Partial	Positive and realistic	No
P5	33w and 5d	2	No	Former smoker/alcoholic /drug addict	Yes	Partial	Positive and realistic	Yes

On the application of the HAD scale, participants P2 and P3 showed indicators of anxiety and depressive symptoms, and participant P1 showed absence of depressive symptoms, but had anxiety indicators. As for WCPS, all patients showed more predominance of strategies focused on the search for religious practices, scores greater than 2.64, and unsatisfactory rates of strategies focused on the search for social support, since scores under the standard deviation below mean (<2.95) are considered values at the clinical level, deserving a detailed assessment to establish intervention goals (Table 3).

Comparing the strategies focused on the problem and emotion, the scores indicate a greater use of strategies focused on the problem, than on emotion. For two participants, it was not possible to apply the HAD and WCP scales, due to the resolution of their pregnancies before the collection of research data (Table 3).

Table 3. Indicators of anxiety and depression and ways to cope with problems of seropositive pregnant women cared for in a general hospital. Ribeirão Preto. May to November of 2018.

Patients	HAD A*	HAD D**	WCPS Problem***	WCPS Emotion	WCPS Religion/Fantasy	WCPS Social Support
P1	9	7	4.17	4.07	4,43	1,80
P2	8	11	4.33	2,00	4,57	2,00
P3	17	12	3.61	2,87	4,14	2,20
P4	----	----	-----	-----	-----	-----
P5	----	----	-----	-----	-----	-----

*Hospital Anxiety Scale ** Hospital Depression Scale *** Ways of Coping with Problems Scale

Through the reading and re-reading of interviews and the analysis of thematic content, it was possible to find four categories: *HIV Diagnosis; Knowledge about HIV; Treatment and Adherence to Drug Treatment.*

HIV Diagnosis

Most find out during pregnancy, but two patients found out in other moments of their lives, as the following quote show:

I found out about HIV right in the beginning of the pregnancy, I was 2 months along. I did the prenatal exams and then came the blow.(P3)

I found out in 2000.... Since I had my 1st child, who was born in 2005, I already knew I had HIV[...] (P2).

Knowledge about HIV

On the patients speeches, it is possible to verify the diagnosis, with emphasis on prognosis, ways of transmission, differences between HIV and AIDS and interruption of antiretroviral medications:

I was told that people don't die of this, they die of other diseases, but if we take the right medicines, we can have a normal life[...](P1)

Now I know that, if I take all the right medicine, I will have a good lifetime[...] I know that, if I do all treatment I will have a life much better than a lot of people who don't have HIV. (P3)

It is possible to catch it on sexual relations, from the needles of injectable drugs, if I cut myself, bleed and other person with an open wound touch my blood, they will catch it. (P1)

AIDS is when you already have the disease [...] HIV is the virus. (P2)

I know I have HIV and I don't have AIDS. (P3)

I don't think so, because before this pregnancy, I was already taking the medicine. (P2)

I don't think there will be a day I won't need to take the medicine, because the virus could become more resistant and then if gets even worse, I already researched that too. (P3).

Treatment

Here were identified themes such as daily ingestion of antiretroviral medications, examinations, and after the birth of the baby:

[...] I need to take the medicine everyday on the right hours[...] (P3)

[...] do the exams to verify the viral load. The treatment consists on blood exams to verify the viral load. (P2)

After I have the baby, the medicine will change, because the one I take is for pregnant women with HIV. I have some questions about the medicine after the birth, but the doctor said I can relax, because she will talk to me about it. She even asked if I intended to stop the treatment after the birth, and I told her no, because I need to take care of my children, so I need to follow the treatment, even if the medicine changes, even if I feel side effects. (P3).

Adhesion to drug treatment

Here the discussion surrounded the act of taking the medication prescribed by the doctor, and also the non-adhesion:

I already went 4 days without taking the medicine, because of a holiday on a Thursday, the Friday was mended and I could only take the medication on Monday. (P2)

At the beginning of prenatal care, I spent about 15 days without taking the medicine, because I was so unmotivated, I was feeling very ill and wanted to give up on the treatment.. (P3)

Just 1 night. (P4)

DISCUSSION

The family income did not exceed R\$ 2,000.00. This result corroborates what a previous research said¹⁴: the most vulnerable groups for exposure to AIDS are women and adolescents, and particularly the economically disadvantaged. However, the data commonly found regarding the low education level of pregnant women with HIV differs from what this study found, since three of the five participants had completed high school. The data released by the Ministry of Health indicate that the majority of pregnant women infected with HIV have educational levels around the 5th and 8th grades (incomplete)¹. The low number of participants in this study makes it more difficult to analyze more reliably information about educational levels that verify the low level of education in people with HIV, and who established this variable as the main cause of the lack of understanding of the forms of transmission of the disease¹⁵⁻¹⁷.

There was an adequate understanding of the stages of treatment by three participants, two of whom had higher education and one did not; and, partial understanding on the part of two participants, one of whom had higher education. As for information about HIV, all patients showed the same level of knowledge, but it is clear that the information was, in some speeches, incomplete and inconsistent. Incorrect data about the virus and the disease may show the occurrence of failures during the process of assimilation of knowledge regarding HIV/AIDS/STD, which occurred in the prenatal period¹⁸.

Studies show that the HIV/AIDS epidemic started in Brazil in the sections of the population with the highest socioeconomic status and then spread, progressively, among those

with the lowest socioeconomic status^{14-17,19}. Based on these findings and the results described here, it can be seen, therefore, that education and socioeconomic level represent less capacity for prevention and understanding of the disease when analyzed alone, but more capacity of prevention when added to other variables, such as difficulty of access to health information and services.

A study shows a profile of pregnant women with HIV with low education and aged between 20 and 35 years²⁰. These data are close to those obtained in the present study, since the age of the patients ranged from 21 to 42 years. These characteristics are also reported in other studies, but the age factor was already expected if we keep in mind that this interval is precisely that in which most women are of childbearing age¹⁵⁻¹⁷.

Another relevant data among the results described is that, regardless of education, most of the surveyed participants knew the risks arising from not undergoing treatment, both for pregnancy and risk of vertical transmission. But it is important to explain that the information obtained by pregnant women about the risks offered to them and the fetus by HIV was not previous, but was due to the situation in which they found themselves, that is, with the confirmation of the diagnosis. In a study with 120 pregnant women, 76.7% agreed with the statement that a pregnant HIV-positive woman is at risk of transmitting it to her baby during pregnancy, while 10% disagreed with the statement and 13.3% did not know how to answer. Regarding the statement that a pregnant HIV-positive woman is at risk of transmitting it to her baby during breastfeeding, only 50% of pregnant women agreed with the statement, 18.3% disagreed with the statement and 31.7% did not know how to answer²¹.

With this knowledge, the offer of anti-HIV testing during prenatal care is essential, as it guarantees to women the right to receive guidance and information about HIV and ways to prevent vertical transmission⁴. The lack of prior knowledge on the participants' part could mean a deficit in the main, and perhaps only, preventive weapon to fight epidemics: the population's awareness of risk behaviors that facilitate the transmission of the HIV virus².

At the time of the study, three of the five participants reported having discovered their HIV status at the beginning of their pregnancy, which corroborates the statements of the Ministry of Health that, currently, a considerable part of the diagnoses of cases of retroviral infection in the female population occurs during the gestational period, reflecting the adequacy of health policy in prenatal care, through anti-HIV serological screening and counseling. The Ministry of Health recommends carrying out an anti-HIV test, which can be understood as a confidential screening test that produces results in a maximum of 30 minutes with a simple methodology, carried out voluntarily and suitable for situations that require prophylactic interventions. specific emergencies, such as the prevention of vertical HIV transmission during childbirth².

Counseling is established as a dialogue based on a relationship of trust established between the professional and the patient, with the goal of ensuring that the patient has conditions to deal with emotional issues arising from their health problem, assessing their own risks, taking decisions and find practical and objective ways to face these problems⁴. However, many professionals are still not trained and prepared to provide specific assistance to infected pregnant women after confirmation of seropositivity. The purpose of assistance is to control viral load and, therefore, reduce the risks of vertical transmission of HIV to the baby¹⁹.

As for the data on emotional indicators and coping, the HAD and WCP scales scores of the three patients showed a greater predominance of the coping strategy focused on religion and fantasy. Religion is related to the role of a collaborator in solving problems, but also to a fanciful expectation of "magical" resolution to the problem. If the focus on religion is directly proportional to the presence of symptoms of anxiety and depression - as it occurred with the participants in this study, given that all of them presented anxiety symptoms and only one did not present depression symptoms - this way of coping will be used in a more fantastical way, in

that the pregnant woman expects the resolution of her problem without actively participating in the process^{23, 24}.

Among the strategies focused on the problem and on emotion, we noticed that the patients prefer to cope while focusing on the problem. This data suggests a proactive attitude towards the problem, in order to manage or modify the situation that caused it²⁵. Thus, we can conclude that the participants knew the risk of vertical transmission and for themselves and sought to change and find solutions to reduce them. The fact that they are doing prenatal care in a tertiary hospital already indicates a proactive attitude towards risk reduction, as the institution provides specialized medical care.

These pregnant women showed less use of the coping strategy focused on seeking social support. This data differs from the study in which all respondents expressed having received some type of support after the discovery of HIV, mentioning family, friends and services as important in coping with this condition. The same study pointed out that some pregnant women reported not seeking support from the family, which was associated with the fear of suffering discrimination by their relatives and also as an attempt to not bring suffering and concern to family members²⁶.

In regards of aspects related to treatment, the team complained about three patients about the inadequate performance of the prescribed actions/behaviors, and four out of the five stated that they stopped taking the drugs (antiretrovirals) at some point. So we can see that the pregnant women in this study, despite receiving complaints from the team about their adherence behaviors and having stopped taking the medications at some point, demonstrated commitment to prenatal care and prophylaxis of vertical transmission. In the case of HIV-positive pregnant women, the fact of being infected with HIV triggers fear of death and of transmitting HIV to the fetus, on the other hand, pregnancy plays a motivational role in which the child becomes a reason for living, generating an effort on the part of the pregnant women to put in practice outpatient practices⁷.

It was possible to understand that the five pregnant women with HIV, especially those who received the diagnosis at the beginning or during pregnancy, realized the need for motivation to live upon the overwhelming news of a condition that has no cure, and that can be transmitted to their fetus, even though the diagnosis brings in its spectrum several elements of death. The participants expressed through their statements that initially the fear of experiencing radical physical and organic changes prevailed, which would make it impossible for them to maintain their routines and plan for the future. Another great anguish experienced was the fear of transmitting the HIV virus to the fetus. A study on the knowledge of HIV-positive pregnant women about vertical transmission also pointed out that the interpretations about the HIV virus are: "*disease that kills*", "*has no cure*", "*represents the end*", "*one who is faced with a positive diagnosis lives a feeling of decree of death anticipated by imaginary equivalence*"²⁶. Pregnant women with HIV experience situations of anxiety, fear and hope and motivation, which are mixed with the many other feelings inherent in the motherhood process⁷.

We can see through the speeches of the patients that the hospital's health team explained the importance of adhering to the treatment in order to reduce the possibility of infecting the fetus and worsening the disease itself whenever there was a deficit in their understanding, with the intention to transmit a vision of health promotion and long-term care. The team proposed to answer all doubts from patients and explain in a clear and easy to understand manner all the aspects that comprise the diagnosis.

Monitoring during the prenatal period helps women to expand their knowledge about their own diagnosis, the forms of prevention and the necessary care during the gestational and puerperal process, representing an important moment for pregnant women to feel safe about monitoring by the health team and, mainly, start to trust the team's recommendations about care⁸.

CONCLUSION

All patients interviewed showed some level of emotional vulnerability, with a predominance of strategies focused on the search for fantastic religious support for coping with problems, a resource that can act as a protective aspect, but also as avoidance, especially when related to anxiety symptoms.

There was dissatisfaction by the health team regarding adherence to treatment by three of the five patients and four acknowledged having stopped antiretroviral therapy at some point, making clear the difficulty that many women have in maintaining adequate treatment in the long term, although with greater responsibility for the treatment. self-care during pregnancy.

This set of observations can raise an alert to the health team about the need for multidisciplinary support and monitoring that can favor psychosocial support to pregnant women, in order to assist in changing or maintaining adherence behaviors. Humanized care, which goes beyond clinical actions, aimed at the prevention and treatment of HIV/AIDS, must consider the emotional and socio-cultural condition of these women. The diagnosis of HIV establishes the need for support that encompasses and articulates the pregnant woman and her network of social and family life, since knowing that she is HIV-positive, due to the uncertainties and fears that she generates around herself and her child, imposes a change from an existential perspective.

The study also shows that, in order for this population to be able to meet health recommendations more effectively, it is essential that pregnant women have a space in which their feelings resulting from pregnancy and the diagnosis of HIV can be expressed and worked on. It was observed that even with the presence of variables that pointed to the incomplete or inadequate performance of prenatal care and measures for prophylaxis of vertical transmission, the patients understood that there would be no possibility of cure on a diagnosis of HIV, but there is a perspective of quality of life for both them and the fetus, if all stages of treatment are properly performed during and after pregnancy.

The present study has as limitations the small number of participants, and the fact that it was not possible to apply the scales to all participants due to the resolution of the pregnancy. However, the data found are relevant because, when linked to other studies, health professionals point out the magnitude of looking at HIV-positive pregnant women as biopsychosocial beings. Listening to their perspectives on the moment they are experiencing allows them to offer quality care, developing strategies that enable better adherence to therapy with antiretrovirals, leading them to realize the need for continued treatment.

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CONTRIBUTIONS

Maria Fernanda Garcia de Almeida and **Maira Morena Borges** contributed in the conception, outlining, quantitative analysis and writing. **Maria Fernanda Garcia de Almeida** and **Cassiana Morais de Oliveira** participated in the qualitative analysis. **Cassiana Morais de Oliveira** worked in writing and revision.

How to cite this article (Vancouver)

Almeida MFG, Borges MM, Oliveira CM. Perceptions on the adherence to treatment and psychological variables of HIV-seropositive pregnant women to HIV/AIDS. *REFACS* [Internet]. 2020 [cited in *insert day, month and year of access*]; 8(3):392-402. Available from: *insert access link*. DOI: *insert DOI link*.

How to cite this article (ABNT)

ALMEIDA, M. F. G.; BORGES, M. M.; OLIVEIRA, C. M. Perceptions on the adherence to treatment and psychological variables of HIV-seropositive pregnant women to HIV/AIDS. *REFACS*, Uberaba, MG, v. 8, n. 3, p. 392-402, 2020. Available from: *insert access link*. Access in: *insert day, month and year of access*. DOI: *insert DOI link*.

How to cite this article (APA)

Almeida, M.F.G., Borges, M.M., & Oliveira, C.M. (2020). Perceptions on the adherence to treatment and psychological variables of HIV-seropositive pregnant women to HIV/AIDS. *REFACS*, 8(3), 392-402. Retrieved in: *insert day, month and year of access* from *insert access link*. DOI: *insert DOI link*.