interface
comunicação, saúde, educação
https://www.interface.org.br
eISSN 1807-5762

Articles

Pregnancy in young people born with HIV: particularities in the contexts of exercising sexuality

Gravidez em jovens que nasceram com HIV: particularidades nos contextos de exercício da sexualidade (resumo: p. 17)

Embarazo en jóvenes que nacieron con VIH: particularidades en los contextos de ejercicio de la sexualidad (resumen: p. 17)

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continue on page 14

The study aimed to understand how young women born with HIV deal with the exercise of their sexualities and the occurrence of pregnancy during their life trajectories. It is a qualitative research, inspired by the Social Constructionist approach to health and the Vulnerability/Human Rights Framework. The 10 participants became pregnant in adolescence and youth (14-21 years old) and were interviewed between 2017 and 2018, in a specialized service in Brazil. Two distinct life trajectory profiles were evidenced: unexpected pregnancy at the beginning of the adolescent's sexual life; desired pregnancy in transition to adulthood. It is concluded that the processes and social markers, which increase the vulnerability to unplanned pregnancy, are common to adolescents in general, however they have particularities by the stigma of HIV, and it is necessary to incorporate sexual and reproductive rights in continuous care for HIV.

Keywords: HIV. Sexual and reproductive health. Sexuality. Pregnancy in adolescence. Adolescent health.

Silva CB, Motta MGC, Bellenzani R, Brum CN, Ribeiro AC. Pregnancy in young people born with HIV: particularities in the contexts of exercising sexuality. Interface (Botucatu). 2022; 26: e210307
https://doi.org/10.1590/interface.210307

Introduction

At the start of the human immunodeficiency virus (HIV) epidemic, women affected by the virus were strongly censored and discouraged by the health team regarding the possibility of becoming pregnant, due to the representation of the idea that this condition did not translate into a familiar and safe place for a child, who would be exposed to a series of risks – drugs, "inappropriate" sexual behavior, socioeconomic vulnerability - resulting in repressed desires, abandonment of treatment, or even abortion[1]. Currently, it is admissible to assume that the advances in technology and clinical treatment make it possible to live better with this chronic disease due to the expansion of future perspectives, which makes it possible to build projects in daily life, including those related to reproduction[2].

In this sense, young women living with HIV demand that health services promote their sexual and reproductive rights[3]. The free, safe and interrelated exercise of these rights is only feasible when sexual life and its possible reproductive consequences are within the sphere of conscious choice and not of the absence of social support, educational guidance and access to preventive resources[4].

However, it is necessary to advance in the discussion of the full exercise of sexuality in adolescence and youth as a right[5], of pleasurable dimension, of intimacy, and of accomplishment of projects, problematizing the normative-preventive discourse that the sexual practice is, necessarily, risky[6]. Envisaging this demand in health is important so that the exercise of sexuality and reproduction no longer occurs in contexts of misinformation and scarce reflection, but rather, with planning that leads to conscious choices and the search for adequate services and resources.

Unplanned pregnancy is defined as resulting from a process in which the free decision of the woman or couple for its occurrence did not exist, which can result from aspects such as difficulty in accessing information and contraceptives in the health service and/or carelessness[7]. It is noteworthy that the social legitimization of gender attributes often lends itself to holding women responsible for the occurrence of an unplanned pregnancy[7].

From this perspective, there is a need for a better understanding of how young women who were born with HIV exercise their sexualities and the reproductive possibilities involved, in order to shed light on possible contexts of increased vulnerability to aggravations in sexual and reproductive health, such as exposure to Sexually Transmitted Infections (STI), reinfection and/or transmission of HIV, in order to plan a comprehensive health care, with practices and approaches centered on their needs and contextualized[6].

From this perspective, this study aimed to understand how young women who were born with HIV deal with the exercise of their sexualities and with the occurrence of pregnancy during their life trajectories.

Method

This is a qualitative research, inspired by the perspective of the Social Constructionist approach to health from the Vulnerability and Human Rights Framework (V&HRF)[8]. It is understood that the notion of vulnerability assists in a broader and less fragmented understanding of the articulated elements - social, cultural and personal trajectories - involved in the production of sexuality and reproduction. Among these, we highlight the elements in the programmatic level, such as access to information, guidance and health care, which strengthen the conditions favorable to the exercise of these rights and, simultaneously, mitigate those conditions of a structural nature that limit such exercise - such as social inequalities, and oppression by gender, color/ethnicity, sexual orientation and identity. These structural conditions add to the difficulties of living with HIV, such as the stigma of the disease that reverberates in discriminations, or even those linked to the very condition of adolescents and young people in certain social contexts.

The study setting was a Specialized HIV Care Service in the southern region of Brazil. Inclusion criteria for the study were: young women (15 to 24 years old) living with HIV through vertical transmission who became pregnant during their youth. The exclusion criteria were: those young women, who were no longer in follow-up in the study setting for reasons of abandonment, change to another service or death.

The contact with the participants occurred through referral from health service professionals on the day they had scheduled appointments. Individual semi-structured interviews were used, with support from the methodology of scenes proposed in the V&HRF which looks to the experience in the terms of those who live it, surveying their repertoire of practices in singularly experienced scenes, in turn, implicated in intersubjective, sociocultural and programmatic settings. The resource to request participants to tell their stories in a more lively way as scenes, when compared to opinions or more unspecific situational reports allows the emergence of processes and relations that express in a clearer way how rights are exercised or undercut in the daily experience, as well as feelings, behaviors, actions and the relationships involved in the scenes[9].

The information collection occurred in a private place in the service, in the period from June 2017 to March 2018. The duration of the interviews ranged from 30 to 90 minutes, being recorded in mp3 audio and later transcribed. The analysis was developed anchored in the reference of the V&HRF[8] so that the most expressive and recurring themes were identified on the trajectories of the young women, which were interpreted, allowing the understanding of the exposure to situations that produce or not conditions for the sexual and reproductive exercise with awareness and access to necessary resources. The study processed a synthesis of the trajectories of the participants, exploring the aspects that possibly act as protective factors or increase exposure, contributing to understanding how the phenomenon of pregnancy occurs.

The ethical aspects were attended, as set by Resolution 466/2012. The participants signed the Informed Consent Form, and all were over 18 years of age. The Research Ethics Committee, under opinions 1.844.848 and 1.912.645, approved the study.

Results

Although the spectrum of possible ages that the research could include was from 15 to 24, the ten research participants were between 19 and 23 years of age, and the ages at which they experienced their first pregnancy ranged from 14 to 21 years. For seven of the ten participants, motherhood occurred during adolescence (14 to 19 years old); for the other three, it occurred in the subsequent age group, at 20 and 21 years old. The subdivision into two groups, corresponding to two profiles of interviewees, organized the presentation of the results of this manuscript. In the analyses, in light of the notion of vulnerability, and seeking to grasp the longitudinality of the life history of each young person with HIV, it was possible to better understand the settings and meanings involved in the different moments of the exercise of sexuality during the life trajectories. Based on this, the meanings about the experiences of getting pregnant manifested with distinctions between the two profiles, not based only on the age group.

For one subgroup, the pregnancy occurred in a more "experimental" context of sexuality, that is, in the configuration of the first relationships and/or sexual partners, in general, "the first courtship," and under the supervision of family members, being something less expected and not consciously planned. For another group of youngsters, the pregnancy occurred at a time of greater social autonomy and in the exercise of sexuality in relation to the family of origin, which along with other psychosocial experiences demarcated the entry into adulthood. Therefore, the experience of pregnancy did not occur in a homogeneous context, nor are its meanings when comparing the two subgroups.

Unexpected Pregnancy Early in Sex Life

This group is composed of six young women, representatives of the lower social classes, according to their socio-demographic information. At the time of the interviews, four of these young women were 19 years old and two were 22 years old. All of them reported low schooling, as well as low professional training/insertion, five of them were unemployed and one worked as an informal worker. Their studies were interrupted on the occasion of pregnancies and the birth of their children, still in adolescence (three young women), of situations of exposure in the school environment of the HIV-positive condition (one young woman); or, still, involving social difficulties for living on the street (one young woman). They presented lower family incomes, denoting financial dependence on family members and government aid. Mothers still alive raised three of the interviewees, one was raised by the father (deceased mother), and two were orphans of both parents (one in a shelter and the other on the street).

The first pregnancy occurred with an average of 16.5 years of age (at 14, 16, 17, and 19 years of age), and three young women experienced more than one pregnancy (two at 19 years of age, another at 17 and 21). Regarding the marital status, three remained with their partners, the children's fathers, in a stable relationship, and three were separated from them, having returned to live with other family members.

The exercise of sexuality, in this group, was permeated by the diversity of affective and sexual partnerships (between one and six sexual partners). The age of the first relationship occurred mostly in the so-called second phase of adolescence, an average of 15.6 years of age (between 13 and 18 years). Three reported that they had other sexual partners before the partner in which the pregnancy occurred.

> I had some " flings", but my daughter's father was my only real boyfriend. [...] He was the second [sexual partner].. (Young woman, 19 years old, one pregnancy at age 16, High School not completed)

> I have had about 6 partners, I went out, I liked to party a lot, but I was not very flirtatious like that. (Young woman, 22 years old, three pregnancies at ages 14, 17 and 21. Elementary school not completed)

These young women began their sexual trajectories in a more impulsive way, and with the expectation that the initiative and attitude toward condom use should be from their partners, who were generally described as unconcerned about protection. Sexual activity was practiced with irregular use of condoms and contraceptives, although they affirmed that they knew the need to prevent themselves, especially with condoms.

> I think I expected too much from him, because the first [partner] had the initiative to prevent himself and he didn't. And I went along with it, I think I was very " charmed". [...] I didn't think it would happen to me. (Young woman, 19 years old, one pregnancy at age 16, High School not completed)

> We used [condoms] from time to time, but it was not like that [...]. I even told him because of the disease too, that there was a chance of passing it to him [...]. But he didn't want to know, he just wanted to "do it". (Young woman, 19 years old, two pregnancies one at age 16 and another at age 19, high school completed)

> He didn't like to use condoms, he thought it was too tight and ended up taking them off [...]. I thought it was a little wrong, but I didn't say anything. (Young woman, 22 years old, one pregnancy at age 19, incomplete high school education)

> We didn't use a condom because it was the first [sexual intercourse] maybe. [...] I knew what people said 'you have to use a condom'. (Young woman, 19 years old, two pregnancies, one at 17 and another at 19, complete elementary education)

Along with the difficulty of bargaining in favor of condom use, it was also evident the difficulty, and the delay, in communicating with partners about the clinical condition of HIV positivity, in general not having occurred before the beginning of sexual relations. Three of these young women reported that they only informed their partners after the pregnancy was confirmed. This communication is important in order to promote the couple's sexual and reproductive health, especially when the decision to suspend condom use is made.

Despite stating that they had some degree of awareness of the risks of unprotected sexual practices due to access to information, the difficulty of revealing living with HIV to the partner prevailed, most likely due to the stigma of the disease, fear of rejection or discrimination. Therefore, the adoption of self-care practices does not happen as a behavior in abstract, but rather, it is contextually constructed, inter-subjective, so that the domain of information, anxieties and fears may even clash.

> At school they have these lectures that show how and why you have to use [condoms] [...]. In the health service they also showed [...] [doctor] said that we could not use it with a person, and he could have it and we could catch different viruses, even though it is the same disease [HIV]. [...] They also talked about other sexually transmitted diseases. (Young woman, 19 years old, one pregnancy at age 16, incomplete high school)

> About condoms, we have a lot of people who talk about it. We hear about it, but we don't use it, right? (Young woman, 19 years old, two pregnancies one at age 16 and another at age 19, high school complete)

> In high school they give the basics to give you a little warning [...] I would like a more complex explanation. (Young woman, 22 years old, one pregnancy at age 19, incomplete high school education)

Both the embarrassment in exposing their doubts or the fear of being morally reprimanded for the exercise of sexuality and the manifestation of reproductive desire, presented themselves as competitors to the performances, in the exercise of sexuality, guided by adequate information and clarifications obtained at school and in the health service.

> I was embarrassed [...] these are things I learned by living. (Young woman, 19 years old, one pregnancy at age 16, incomplete high school)

> I would have liked [to have had more conversations], even to be aware that the moment was not right to have a child. (Young woman, 19 years old, two pregnancies one at age 16 and another at age 19, high school complete)

> I don't really like to talk about it. [...] We wanted to get pregnant [second pregnancy], they would just say you can't. I didn't want to hear that. I didn't want to hear that. (Young woman, 19 years old, two pregnancies, one at age 17 and another at age 19, complete elementary education)

Most of the young women in this group stated that they did not plan their pregnancy, meaning it as an oversight. One young woman reported that her first pregnancy was motivated by the desire to be independent, to be "emancipated" from her family, but without planning how to do it. Secondary pregnancies were reported by two young women in a life context that allowed them to be planned.

I didn't take care of myself, I didn't use contraception, I thought it would never happen, just little girl thoughts. And then I got pregnant. It happened very fast. (Young woman, 19 years old, one pregnancy at age 16, incomplete high school)

> We sometimes used condoms. [...] [in the third pregnancy] my husband wanted a child. (Young woman, 22 years old, three pregnancies at ages 14, 17 and 21. Elementary school incomplete)

> We wanted to get married and my mother wouldn't let us. I think that's why I mostly rebelled, that I didn't take care of it properly. [...] then the baby came, when I didn't want it anymore [first pregnancy] [...] I found out I was pregnant and we had already separated [about the second pregnancy that was not planned] (Young woman, 19 years old, two pregnancies one at age 16 and another at age 19, high school completed)

Desired pregnancy in the transition to adulthood

This group is composed of four young women, ages 21, 22 and two, 23. Compared to the previous group, they had a higher level of education and family income; two quit their jobs to take care of their children, one continued working, and another did not work, therefore depending in general, on her partner's salary. All were orphans of both parents, having been raised by other family members; and one was in a shelter situation.

Pregnancies occurred at an average of 20 years of age (19, 20, and 21), and all the girls had only one pregnancy. Regarding marital status, all remained with their partners in a stable relationship.

The exercise of sexuality, in this group, was permeated by trajectories with less diversification of sexual partnerships (between one and two partners), being mostly in stable relationships with the current husband/partner. The first sexual relation occurred later, with an average of 17.7 years of age (at ages 17, 19 and 20; only one young woman reported initiation before age 15).

> I started dating when I was only 19 [with my current husband]. My uncle joked with me that he was going to put me in a nun's school. (Young woman, 23 years old, one pregnancy at the age of 21, high school complete)

> I went out with friends, but I wasn't a flirt. I never liked to stay with one or the other. [...] I had another partner before. [...] It was my second sexual partner. (Young woman, 22 years old, one pregnancy (at age 19) that resulted in a miscarriage, incomplete high school)

> I had only one boyfriend before my husband, when I was 18, because my grandmother held me back a lot. I didn't go out, nothing like that. But the first [sexual] relationship was with my husband, when I was 20. (Young woman, 23 years old, one pregnancy at the age of 20, incomplete elementary education)

Sexual relations were practiced with more regular use of condoms and contraceptives than in the previous group. All partners were aware of their partners' HIV status prior to initiating sexual intercourse.

> I always used a condom and took birth control too [before I got pregnant]. [...] My aunt, at school, the doctors also talked. (Young woman, 23 years old, a pregnancy at 21 years old, complete high school)

> I knew how to prevent pregnancy; we got condoms at the health center, both him and me. I took the pill, and then I took an injection. (Young woman, 22 years old, a pregnancy at age 19 that resulted in miscarriage, incomplete high school)

As a source of access to information for the promotion of sexual and reproductive health, this group pointed to the school, the health service, but also family members and the media. However, they pointed out the need for more information, beyond the recommendation of condom use, but addressing conception and prophylaxis of vertical transmission in a more effective way.

> The doctors talked to her, asked if she had a boyfriend, a flirt. They talked about the use of condoms, the pill, about having to take care of you. [...] at school they gave lectures [...] We see it in soap operas, in the newspaper, everywhere. (Young woman, 23 years old, one pregnancy at the age of 21, high school complete)

> They [health professionals] talked about condoms, about having to take care of you to avoid passing it to another person, nothing beyond that. [...] Now I know [ways to prevent pregnancy], I already put implanon. (Young woman, 23 years old, one pregnancy at the age of 20, incomplete elementary education)

> I got to know after I grew up, that's when I started to ask. [...] I only knew after I talked [with a doctor] about how I could get pregnant. (Young woman, 21 years old, one pregnancy at the age of 20, incomplete high school)

It was identified in this group that the reproductive plans were made after the stable relationship was established, as a more reflected decision about pregnancy as part of the life projects, contemplating a shared desire of the couple. Despite this, only three participants reported having talked to a health professional about their desire. Positively, two young women carried out the reproductive planning accompanied by a health service.

> I told the doctor [infectious disease specialist] that I wanted to get pregnant, she told me to make an appointment with the gynecologist to talk and plan the pregnancy, that I could have a child, do the treatment, but I only had an appointment for November and it was July. In November I was already pregnant. [...] My husband researched and saw that those who had undetectable viral load were not so likely to pass it, that one time they would not catch HIV and that my exams were great. [...] Then it ended up happening. (Young woman, 23 years old, one pregnancy at the age of 21, high school complete)

> I used to take the pill, then I stopped because I wanted to get pregnant, but I wasn't planning, it was all very fast [suffered a miscarriage 3 years ago] [...] I already want another [child]. I talked to the doctor that I wanted to get pregnant, and now she gave me the break intervals, everything right, as it was supposed to get pregnant. I think it's important so that nothing goes wrong. (Young woman, 22 years old, one pregnancy at age 19 resulting in miscarriage, incomplete high school education)

> I came to the doctor, he told me that I had to stop the injection and explained how I had to do it, he said I could keep trying, but I had to go to the health center [...] he [partner] had to take medication for 3 months to avoid becoming infected. (Young woman, 21 years old, one pregnancy at the age of 20, incomplete high school)

Discussion

Two groups of young women with distinct profiles were evidenced, regarding the contexts of daily life, social determinants, and the exercise of sexuality, even though all the young women had, in common, living with HIV since birth. One group of young women experienced the unexpected pregnancy, when they had their first sexual experiences in a more "recreational" way, therefore, closer to what is called unplanned pregnancy, or unwanted pregnancy. In another group, the entrance in the reproductive life occurred as an expected fact of adult life, as part of the affirmation of the feminine identity, and the pregnancy could not be denominated as unwanted or unplanned.

Therefore, it is important to point out that the events in the reproductive sphere of the young women studied do not make them atypical; on the contrary, they follow the trend called the "youth pattern" of Brazilian national fertility - observed regionally, throughout the country[10]. That said, it is signaled that, although there are particularities in the production of vulnerability to an unplanned pregnancy, specific to the condition of being born and living with HIV of these young women, and of the health system that assists them for this clinical condition, these particularities, in isolation, are not enough to understand the issue listed.

Thus, it is necessary to analyze these particularities in the light of the demographic transformations that have been taking place in Brazil in the last decades, among those trends, the transition of fecundity[10]. The drop in overall fertility is represented especially by the decrease in women at middle and older ages in the reproductive period, when compared to the fertility of adolescents and youth. Although the country shows an important decline in the fertility of adolescents and young people from the year 2000 on, the rates are high and significantly higher compared to the world rate, and even the Latin American rate with other countries[11], this shows that there is still a long way to go when it comes to preventing unplanned pregnancies at an early age.

This contextualization in relation to the results of the study is relevant, since it contributes to dispelling the misconception that the condition of living with HIV is the determining aspect in the production of vulnerability to an unplanned pregnancy among the young women surveyed. Fertility concentrated in the youngest ages, whether planned or unplanned, encompasses psychological, social, cultural, economic and political elements that are articulated in a procedural and complex causality that goes beyond the condition of living with HIV, and the health care that they access, or not, in the specialized services offered by the national HIV policy[10].

In this way, the experiences of sexuality and reproduction should be understood in a dynamic and processual way, according to human development, episodes throughout life and contexts of sociability and socialization. This refers back to gender scripts, in which social standards are established in ways that promote or hinder female empowerment around personal motivations/desires, respect for the right to choose, and the search for resources to prevent and protect sexual and reproductive health[12]. These scripts can be incorporated by the young woman born with HIV in a less critical or resigned way, depending on socio-educational processes and daily experiences.

In the trajectories of the participants, there were scenes that highlighted the vulnerability to unprotected sexual activities, especially in the adolescent phase, when there was a greater tendency to delegate condom use to partners, in a relationship of less empowerment

In the first group of young people, who began their sexual lives earlier and in a more experimental context, less committed and less planned, we can identify the attitude of waiting for the male initiative or giving in to the partner's will in unprotected sexual intercourse.

This attitude reveals the barriers in the process of bargaining the use of condom and announces the sociocultural construction of women's role in affective relationships under the gender stereotypes[13] of passivity, delegation of decisions, trust and submission, permeated by the fear of displeasing or losing the partner. The absence of dialogue

and negotiation creates a scenario of silence that limits actions and exposes them to the risk of STIs, an unplanned pregnancy, and the curtailment of their rights to choose[13]. This behavioral pattern is present in adolescent girls in general, and becomes particularly serious in the context where HIV is known to exist, that despite recognizing the importance of avoiding reinfection and/or the risk of partner infection, this was subjectively second-guessed by them, and sometimes by the partner himself, when aware of the partner's HIV-positive status.

Thus, this group of aspects configured in this group the experience of a fortuitous, unplanned and unthought-of pregnancy. If on the one hand, the peer group in adolescence pressures them to experience sexuality; on the other hand, there is family/social repression when pregnancy occurs. Behind an apparent liberality, there is often a rigid and punitive morality when family values are transgressed[14].

It is noteworthy that there is negligence at the programmatic level, by the structured services, so that the fertility rates decrease in adolescence and youth (when unwanted). The particularity of living with HIV constitutes an aggravating element in the production of vulnerability in sexual and reproductive health, due to the fact that it affects these young women with more intensified social disapproval, and moralizing stance, setting up a violation of their rights.[2] Although professionals are more tolerant of pregnancy in the context of HIV, there is still discrimination and discouragement, which contribute to the omission of desires and decisions[15].

The second group shows that some of these young women had already entered a young-adult life, in which the affective and sexual relationship occurred later and with greater stability, even sometimes being encouraged by a more restrictive upbringing in sociability and sexuality. Disciplinary discourses under the gender approach in the upbringing and education of young girls directly interfere in the building of their identity and in the libertarian or restrictive posture they will assume in their sexual and reproductive exercise[12].

The pregnancy in this group occurred in the context of stable relationships and was planned by the couple. In this way, to label pregnancy in youth as necessarily unwanted or precocious is mistaken, because many plan it and get pregnant by their own desire[16]. Reproductive desire occurs, as it does in young women who do not have this health condition, and it sometimes stems from the valorization of women in society and focuses on a change in social status[17].

The STI and/or pregnancy preventive behaviors are consolidated through the informed decision and the possibility of practicing safe sex[18], and that knowledge does not necessarily predispose to behavior change, because it can compete with norms, values and representations that conform the intersubjectivity. This approach is postulated in a dialogical context that elucidates the psychosocial dimension of the lives of young women, in which they can participate in care as conscious protagonists, subjects of rights and duties[6].

From this perspective, it was evident that the access to information about sexual and reproductive health, in both groups, was superficial and sporadic, focusing on the biological dimension and on the normative recommendation of condom use. This indicates the importance of addressing the issue continuously, gradually and transversally, throughout clinical follow-up, growth and development, in order to build healthy and safe practices. Interventions and dialogues are needed that allow the decoding of normative patterns and sociocultural influences on personal experiences, thus achieving a more comprehensive care, which covers the psychosocial dimension[9], that is, daily life and projects of happiness and life, moving towards the realization of sexual and reproductive rights as human rights[19].

The social avoidance of dialogue about sexuality both in the family environment and in health services, sometimes due to difficulties of the family members and professionals themselves to discuss it[16], contributes to the production of insecurity and shame in approaching the subject by young women. In the context of the HIV seropositive experience there is an additional condition of silencing, resulting from the fear of stimulating the risk of transmission or reinfection of the virus.

However, young women aspire for more detailed information that relates to the scientific and technological advances of HIV in the dilemmas they face. Regular meetings between professionals and young people can enable the building of bonds of trust and acquire potential "windows of opportunity[20]. to address these issues[21]. Moreover, the expansion of methods available in the network of services (contraceptive methods, assisted reproduction, treatment as prevention), can help reducing the incidence of the epidemic and consolidate sexual and reproductive rights, especially if based on prevention strategies[22] appropriate to the context of life. It is also imperative to recognize primary care, in large part through the Family Health Strategy, as a space with the potential to increase health promotion for adolescents and young people, by defining their attributions in the context of HIV and strengthening the capacity for communication between services[22].

Early motherhood, especially in the face of social inequalities, increases the chances of school dropout, losing training and professional inclusion, in addition to socioeconomic and family/partner implications, and may cause frustration, dissatisfaction, and lack of life perspective. In the context of HIV, the clinical context and the risk of illness of those involved are added, making the involvement of society, family and health professionals essential for effective care to this population[21], so that young women can manage their treatment and a "safe" sexuality[23].

Final remarks

By understanding the way how young women born with HIV deal with the exercise of their sexuality and with the occurrence of pregnancy, it is reinforced that pregnancy in this population does not differ, in general, from the context without the presence of HIV, in which emerge the elements highlighted in the configuration of vulnerability to unplanned pregnancy in youth, in which act synergistically in addition to structural socioeconomic issues, the submission to social norms and asymmetrical gender relations, the lack of access to information, sex education and comprehensive health. The HIV positive condition is followed in this context by a greater social silencing in sex education, for fear of stimulating sexual activity in the presence of STIs, in order to stop the chain of transmission. Thus, it is essential that the care offered includes not only the "more typical" aspects of the age phase, but also those arising from the HIV-positive condition - exposure to stigma/discrimination and social disapproval regarding the exercise of sexuality and reproduction - in intersectionality with other social markers that produce inequalities and inequities.

This identification of social markers in the analysis of vulnerabilities in the exercise of sexuality and reproduction in the context of HIV helps to overcome simplistic understandings of pregnancy in adolescence/youth, which tend to be restricted to individualizing explanations and accusations of irresponsibility and immaturity. The complex synergy of social and programmatic aspects that express themselves at the individual level of personal trajectories is elucidated. This perspective contributes to the management of elements that could subsidize the performance of health professionals, with more adequate and efficient health intervention initiatives attending to sexual and reproductive demands, about the best time, resources and compatible actions, whether in the family, social environment or health services. It is considered that the absence of sexual education and of acceptance of reproductive desires results in vulnerability to unplanned pregnancy or to a pregnancy about which little thought was given before its discovery.

Since this is a study carried out in a single health service, the results may have some limitations due to its specificities. However, the trends of the results suggest issues for other investigations, as well as contribute to the improvement of health care and public policies for the sexual and reproductive rights of girls who were born with HIV.

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Authors' contribution

All authors actively participated in all stages of preparing the manuscript.

Funding

This work was carried out with the support of the Coordination for the Improvement of Higher Education Personnel - (Coordenação de Aperfeiçoamento de Pessoal de Nível Superior) - Brazil (Capes) - Funding Code 001.

Conflict of interest

The authors have no conflict of interest to declare.

Editor
Ana Flávia Pires Lucas D'Oliveira
Associated editor
Dulce Aurélia de Souza Ferraz

Translator
Félix Héctor Rígoli

Submitted on
05/10/21
Approved on
11/19/21

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O estudo objetivou compreender como mulheres jovens que nasceram com HIV lidam com o exercício de suas sexualidades e com a ocorrência da gravidez durante suas trajetórias de vida. Esta pesquisa qualitativa foi inspirada na abordagem Construcionista Social em Saúde e no Quadro da Vulnerabilidade/Direitos Humanos. As dez participantes engravidaram na adolescência e na juventude (14 a 21 anos) e foram entrevistadas entre 2017 e 2018, em um serviço especializado da região Sul do Brasil. Evidenciaram-se dois perfis de trajetórias de vida distintos: gravidez inesperada no início da vida sexual da adolescente; gravidez desejada na transição para a adultez. Conclui-se que os processos e marcadores sociais, que ampliam a vulnerabilidade à gravidez não planejada, são comuns às adolescentes em geral, contudo particularizam-se pelo estigma do HIV, sendo preciso incorporar no cuidado contínuo em HIV os direitos sexuais e reprodutivos, fortalecendo a dimensão psicossocial do cuidado.

Palavras-chave: HIV. Saúde sexual e reprodutiva. Sexualidade. Gravidez na adolescência. Saúde do adolescente.

El objetivo del estudio fue comprender cómo mujeres jóvenes que nacieron con VIH manejan el ejercicio de sus sexualidades y el surgimiento del embarazo durante sus trayectorias de vida. Investigación cualitativa inspirada en el abordaje Construccionista Social en salud y en el Cuadro de la Vulnerabilidad/Derechos Humanos. Las diez participantes se quedaron embarazadas en la adolescencia y juventud (14 a 21 años) y fueron entrevistadas entre 2017 y 2018, en un servicio especializado de la región Sur de Brasil. Quedaron en evidencia dos perfiles de trayectorias de vida distintos: embarazo inesperado en el inicio de la vida sexual de la adolescente; embarazo deseado en la transición para la edad adulta. Se concluyó que los procesos y marcadores sociales que amplían la vulnerabilidad para la gravidez no planeada son comunes entre las adolescentes en general, sin embargo, se particularizan por el estigma del VIH, siendo preciso incorporar en el cuidado continuo de VIH los derechos sexuales y reproductivos, fortaleciendo la dimensión psicosocial del cuidado.

Palabras clave: VIH. Salud sexual y reproductiva. Sexualidad. Embarazo en la adolescencia. Salud del adolescente.