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Reproductive planning and pregnancy of HIV serodiscordant couples: a phenomenological study

Planejamento reprodutivo e gestação de casais sorodiferentes para o HIV: um estudo fenomenológico

Planificación reproductiva y embarazo de parejas serodiscordantes para el VIH: uno estudio fenomenológico

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ABSTRACT

Objective: To understand the experience of reproductive planning and pregnancy for HIV serodiscordant couples.

Method: Qualitative study, with phenomenological approach, theoretical-philosophical-methodological framework of Martin Heidegger. The field stage took place in a reference service in the care for people living with HIV, in southern Brazil. From an intentional sample, a phenomenological interview was conducted with 11 couples between August 2013 and April 2014. The analysis was hermeneutic.

Results: It was possible to understand, from the meaning units that: couples accept and overcome the serological discordance together; experiencing pregnancy is difficult; there is an effort to have a normal life; the diagnosis is silenced by prejudice and stigma; comes the couple's relief after the child's negative diagnosis.

Conclusion: It is necessary to recognize the couple as a unit of care with a view to a non-fragmented care in the field of sexual and reproductive health.

Keywords: Reproductive rights. HIV. Pregnancy. Philosophy, nursing. Nursing.

RESUMO

Objetivo: Compreender o vivido do planejamento reprodutivo e da gestação para casais sorodiferentes para o HIV.

Método: Estudo qualitativo, na abordagem fenomenológica, referencial teórico-filosófico-metodológico de Martin Heidegger. A etapa de campo foi em serviço de referência na atenção a pessoas soropositivas, no Sul do Brasil. A partir de amostra intencional, foi realizada a entrevista fenomenológica com 11 casais entre agosto de 2013 e abril de 2014. A análise foi hermenêutica.

Resultados: Foi possível compreender, a partir das unidades de significação que: os casais se aceitam e superam juntos a diferença sorológica; vivenciar a gravidez é difícil; há empenho para se ter uma vida normal; o diagnóstico é silenciado pelo preconceito e estigma; vem o alívio do casal após o diagnóstico negativo do filho.

Conclusão: É necessário reconhecer o casal como uma unidade de cuidado com vistas a uma atenção não fragmentada no campo da saúde sexual e reprodutiva.

Palavras-chave: Direitos sexuais e reprodutivos. HIV. Gravidez. Filosofia em enfermagem. Enfermagem.

RESUMEN

Objetivo: Comprender la experiencia de planificación reproductiva y embarazo de parejas VIH serodiscordantes.

Método: Estudio cualitativo, en el enfoque fenomenológico, marco teórico-filosófico-metodológico de Martin Heidegger. La etapa de campo se llevó a cabo en un servicio de referencia en la atención a personas que viven con VIH, en el sur de Brasil. A partir de una muestra intencional, se realizó una entrevista fenomenológica con 11 parejas entre agosto de 2013 y abril de 2014. Análisis hermenéutico.

Resultados: Fue posible comprender, a partir de las unidades de significado, que: las parejas aceptan y superan juntos la discordancia serológica; vivir el embarazo fue difícil; hay esfuerzo por tener una vida normal; es silenciado por el prejuicio y el estigma; llega el alivio de la pareja tras el diagnóstico negativo del niño.

Conclusión: Es necesario reconocer a la pareja como unidad de cuidado con miras a no fragmentar la atención en el campo de la salud sexual y reproductiva.

Palabras clave: Derechos sexuales y reproductivos. VIH. Embarazo. Filosofía en enfermería. Enfermería.

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INTRODUCTION

Periodically, the UNAIDS (Joint United Nations Programme on HIV/AIDS) publishes global and regional estimates and stats on the HIV epidemic. In 2020, about five thousand young women aged 15-24 years were infected with HIV and accounted for 50% of all new weekly infections[1]. Besides universal antiretroviral treatment (ART) for all women, there are also reproductive demands and the right to exercise fatherhood and motherhood, which deserve planning by couples, regardless of their serological condition, that is, whether they are serosame or serodiscordant (those in which only one of the partners is seropositive)[2].

These are challenges for health services that can be mediated by care based on reproductive planning, looking on issues such as assisted human reproduction, safe natural conception and contraceptive methods[2–3]. But there is also an interest in understanding the experience of serodiscordant couples in maintaining their reproductive and sexual health. Giving voice to the couple reflects the effort of including men in reproductive care, often placed as woman's responsibility. A study investigating barriers and facilitators for male participation in prenatal care for the purpose of voluntary HIV testing indicates that they would accept the test if offered and understand the need for prevention for the health of their family, but highlight the lack of male involvement in reproductive planning[4].

To evaluate the beneficial effect of men's involvement in prenatal care, a systematic review found that involving a male partner in prenatal care was associated with qualified service at birth and had a positive impact on understanding maternal health[5].

Considering the specificity of HIV serodiscordance, there are other issues with the vulnerability of couples in the experience of their sexual and reproductive rights. Among them, the fear of infection of the negative partner[6] and the silencing or non-disclosure of the serological condition for fear that the child and those who are HIV negative are vulnerable to situations of prejudice and discrimination for living together with who is HIV positive[7].

Thus, we have as a research question: what are the experiences of serodiscordant couples for HIV in the face of reproductive planning and pregnancy? Thus, the objective of the study is: to understand the experience of reproductive planning and pregnancy for HIV serodiscordant couples.

METHOD

The phenomenological hermeneutics based the study on screen, grounded in the theoretical-philosophical-methodological framework of Martin Heidegger. The method allows to understand what is not immediately shown, veiled in a first approximation and which, based on a comprehensive analysis, has identified its meanings and leads to the interpretation of the senses, unveiling the phenomenon[8].

The 11 couples interviewed were accessed in sectors that provide integrated care to potential participants, at a university hospital (UH), located in the interior of Rio Grande do Sul state, Brazil, which is a reference for the care of people living with HIV in the municipality and in other 31 municipalities linked to the 4th Regional Health Coordination of the State. The number of participants was not predetermined, as the phenomenological study considers the essence of what is shown, the sufficiency of meanings to respond to the research objective, and not the number of interviews performed.

The eligibility criteria were: (a) heterosexual couples, (b) with knowledge of the partner's diagnosis at the time of the interview, (c) experienced at least one pregnancy in a situation of HIV serodiscordance. The exclusion criterion was: (a) when the man or woman had alterations in the cognitive process of thinking.

The researcher invited the participants at the health service, when the objectives and reasons for the development of the research were presented. Then, contact was made via telephone to schedule the date and place of the interview. These took place at the service or at the participants' residence, according to their preference and were recorded with a digital recorder and transcribed. The couples answered the interview questions together, understanding that to access the phenomenon studied, it would be necessary to listen to them together. Only one couple refused to participate in the research due to the sensitive topic.

The technique for data collection was the phenomenological interview[9], guided by a script with open questions, tested in the first interviews and applied only after adjustments. It is highlighted that they were guided by the Heideggerian theoretical framework and the phenomenon of study and started with the following guiding question: How was the planning and pregnancy of this child for you? When the couples did not elaborate in their statements on the issue of serodiscordance, the second question was mentioned: How was the planning and pregnancy of this child in the situation of serodiscordance for you?

The first author, a nurse researcher, with experience in the theme and in the method, conducted all the interviews from August 2013 to April 2014. The interviewer did not previously know the participants. During the interviews, she projected an attitude of open listening to the responses, being attentive to the ways in which the couples showed themselves and the movement established in this meeting by them. She adjusted the guiding question with empathic questions converging to the research objective to deepen the meanings expressed. There was complementarity in the speeches between men and women, so that none were suppressed, hindered or felt intimidated to speak.

The analysis was performed at the same time with the field stage, when the first author listened to each interview several times to understand the data and determine the sufficiency of meanings expressed in the couples' speeches to reach the objective of the study[9]. Furthermore, the other authors discussed the need for new questions and, in consensus, determined the end of the field stage. The method of analysis of Martin Heidegger[8] proposes two methodical moments: (a) Vague and Median Understanding and (b) Hermeneutics. For the development of the first, readings and re-readings of the interviews were conducted in order to identify and highlight the essential structures, which constitute the meaning of the investigated phenomenon. These structures are those expressed by couples as significant experiences about the phenomenon corresponding to the objective of the investigation.

After elucidating and clustering the meanings, the caput of the unit was elaborated – statement, heading or title of the a posteriori category that constitutes the Meaning Unit – (MU) respecting the words and expressions said by the couples. The MU, together with the phenomenological discourses (detailed and textual descriptions of the set of meanings expressed in the interviewees' statements), compose the vague and median understanding. For elaboration of the phenomenological discourses, the researcher tried to strictly follow the description of the meanings using words and expressions said by the couples.

The vague and median understanding concerns the ontic dimension of the phenomenon, which can be immediately perceived[8]. It refers to the facts, to what is given and can be explained. Thus, the meanings sought in this methodical moment can be understood as what is factual for the HIV serodiscordant heterosexual couple in the experience of reproduction.

Hermeneutics, the second methodical moment, looks on the interpretative analysis of the meanings apprehended from a vague and median understanding, with a view to the possibility of unveiling phenomenal facets of the investigated object of study. This is a hermeneutic movement that allows moving from the ontic, factual, to the ontological, phenomenal dimension. In the ontological dimension, it is possible to meet the essence of being[8].

The rigor in the development of research permeates the concept of credibility. For this, the analysis stage was supported by the team of researchers who discussed the meanings and validated the meanings unveiled in the light of the Heideggerian framework. To ensure reliability, two members of the research team reviewed the transcripts and the agreement of meanings to maintain the thread for the analysis. At completion, the analysis was critically reviewed by the first author, who reflected about her own theoretical positions during the course of the study to confirm the process of analysis. We understand that transferability is configured in the description of the experiences of the couples in the sample[10]. This process improved the development of the research and ensured the rigor undertaken.

The protocol was approved by the Research Ethics Committee of the institution (opinion:367,670) and all couples provided written informed consent. To ensure anonymity, the names of the participants were replaced by the codes W for woman, M for man and C for child, when the child was mentioned in the statements by the parents, followed by the numbers 1 to 11 (W1, M1, C1; W2, M2, C2; successively). The ethical aspects of research involving human beings were complied, following Resolution 466/12 of the National Health Council.

RESULTS

Participant characteristics

To obtain these data, a pre-elaborated instrument was not applied. These were elaborated from the statement of the couples, expressed by them as significant facts in their experience. Thus, in Chart 1, information/facts are presented, revealing what each couple has and the composition of their historiography[8].

	couple 1	couple 2	couple 3	couple 4	couple 5	couple 6	couple 7	couple 8	couple 9	couple 10	couple 11
Serological status at fecundation	SD	SD	SD	SD	SD	SD	SD	U	SD	D	SD
Serological status at interview	SD	SS	SD	SD	SD	SS	SD	SD	SD	SD	SD
Who was/is seronegative	W	W	M	M	W	W	M	M	M	M	M
Pregnancy planning	Yes	No	No	No	No	No	No	No	No	No	No
Type of conception	Artificial (RHA)	Natural	Natural	Natural	Natural	Natural	Natural	Natural	Natural	Natural	Natural
Contraceptive method	Does not mention	OC	Does not mention	OC and condom	Condom	None	Condom	Does not mention	OC	None	OC
Obstetric history + Pregnancy in serodiscordant situation	P1D1A0 One	P7D7A0 One	P4D3A1 Two	P4D1A3 Two	P2D2A0 One	P1D1A0 One	P3D3A0 One	P1D1A0 One	P2D1A0 Two	P3D3A0 One	P4D3A0 Three
Desire to get pregnant	Yes	Does not mention	Yes	Yes	No	Yes	No	Yes	No	No	No
Child's serology	Negative	Negative	Negative	Negative	Negative	Negative	Negative	In follow-up	Negative	Negative	Pregnant
Child's age	1y. and 8m.	Died 1 y. and 1m.	Does not mention	10 y.	5 y.	8 y.	Died 4 y. and 5 m.	3 m.	Pregnant	8 months	Pregnant

Chart 1 – Information corresponding to the historiography of the participants. Santa Maria, Rio Grande do Sul, Brazil, 2022

Source: The authors, 2022.

*Note: OC = oral contraceptive; U = unknown; SD = serodiscordant; SS = serosame; W = woman; M = man; PDA = female parity, where "P" refers to the number of pregnancies, "D" to the number of deliveries and "A" to the number of abortions.

Next, the phenomenological statements will be described, elaborated from the vague and median understanding, to apprehend the essential meanings attributed by the participants.

The following were unveiled: MU1 - They accept, overcome and take care of themselves together; MU2 - It was a very difficult pregnancy, because they had to undergo treatment to not pass something on to the child and they are grateful because everything went well; MU3 - They hide the HIV and serodiscordance situation because of prejudice; and MU4 - They try to live normally as if they didn't have the disease, counting on an improvement in the situation after the child's birth.

MU1 – They accept, overcome, and take care of themselves together. Couples express the overcoming of the serological discordance by reporting the characteristics of each one and the acceptance of the other. They express that it is a relief for the partner not to have HIV and to be well, because it is not necessary to carry everything alone. The partner was very present, takes care of the partner and the child, because they fear future events. Thus, they "take over", love each other, are happy and take care of each other together. In this pregnancy, everything was different, because of the need of doing the treatment, which is new and affects psychologically. Follow-up requires effort and is exhausting, involves the need to do many exams, medicines, and right schedules. The illustrations of the speeches expressed the meanings of the MU1 and also refer to couples 5,6,8,9, 10 and 11.

> [...] *we accepted to be different* [...] *we worry* (W1) *our life is peaceful* [...] *everything is very planned. Health insurance, everything, for me to be able to defend them* (M1)
>
> *we had work together* [...] *none of them carried it all alone* (W3) *in these nine months of pregnancy I was very supportive* [...] *helping her and then helping my son* (M3)
>
> *the only person I can rely on is just him, I can only count on him, I can't count on other people* [...] *he understood and understood me* (W4) *I love her, and we have to take care of ourselves* [...] *hard to know that she has it and maybe I don't have it* [...] *we've been together for 14 years* [...] *we help each other and go on* (M4)

MU2 – It was a very difficult pregnancy, because they had to undergo treatment to not pass something on to the child and they are grateful because everything went well. Couples study and seek information to understand about HIV infection, pregnancy, the least risky type of birth and child care. They are almost certain that the child will have nothing, but even with the treatment and everything that must be done, there is tension. When they start prenatal care, they think everything will be fine. After the child is born, they need to do follow-up in pediatrics and wait for six months to be discharged. Parents are patient, conform and are only reassured by knowing that they have not passed anything on to their child. The illustrations of the speeches expressed the meanings of the MU2 and also refer to couples 1,2,3,4,8, 7 and 11.

> *I didn't get it neither her* [C5] [...] *I did all the tests that she* [physician] *asked me* [...] *because 6 months she* [C5] *has my antibodies* [...] *then I was calm* [. ..] *thank God there was nothing* (W5) *I always took care of my CD4* [...] *my friend who consults with a private infectologist tells me everything* [...] *I was almost sure that she* [C5] *would not have anything and thank God* [didn't have it] (H5)
>
> *It's a good thing neither of them have* [...] *thank God they're fine* (W9) *one can't live 100% the joy of pregnancy* [...] *I managed to have that full happiness when I got the news that she would be fine* (M9)
>
> *Doing the treatment correctly* [...] *it was all different, everything was new* [...] *but psychologically that I was shaken* (W10) *In the first weeks you have to start the treatment* [...] *he was born well, there was no problem, the worse has passed* [...] (M10)

MU3 – They hide the HIV and serodiscordance situation because of prejudice. Couples report talking to each other about people's reaction to HIV infection and they perceive prejudice, which is why they make the diagnosis confidential even within the family. In some cases, the relatives of those who do not have HIV are the ones who support, give strength to the couple, while those who have HIV have prejudice. Therefore, they do everything themselves and only the people from the health service know the situation. The illustrations of the speeches expressed the components of MU3 and also refer to couples 1,2,3, 5 and 6.

> *It worsened when I told mother, so I prefer to be alone between the two of us* (W8) *We stay between the two of us, we try not to tell, even if it is a person you trust* (M8)
>
> *The only person who knew was only M10* [...] *my family found out and gave much greater support, you know* (W10) *But until then her family did not know* (M10)
>
> *The only thing he asked was not to tell anyone* [...] *my family* [doesn't support me] (W11) *There is a lot of prejudice* [...] *we don't even talk about it, make it confidential because people have prejudice* [...] (M11)

MU4 – They try to live normally as if they didn't have the disease, counting on an improvement in the situation after the child's birth. The statements express that couples get used to it and live normally, just needing to be careful with the medicines and go to the hospital for consultations. When the child is born, they forget the bad things (difficulties in doing the treatment and fear about its effectiveness) and dedicate themselves totally to it, taking care and doing whatever is necessary for their health. For couples, having a child was a dream come true, in which the effort and suffering resulted in having a healthy and strong child, making them see life differently. They feel the joy of being a father and mother. The illustrations of the lines expressed the meanings of the MU2 and also refer to couples 3,4,5,6,7, 8 and 10.

> *I forget that* [...] *tries to live normally* [...] [C1] *is the accomplishment* [...] *he has fulfilled us completely* [...] *as a mother and as a father* [...] *it makes much more sense in life* (W1) [...] *you have to be careful, don't forget to take your medicine* [...] *we live 100% normal* [...] *after he came it was wonderful* [...] (M1)
>
> *We live normally* [...] *we are normal people* [...] *Son has always been a blessing for us* (W2) [...] *About nine years* [when discovered the diagnosis], *for three years i have been taking medicines and I live normally* [...] *we live normally* (M2)
>
> *I keep thinking about the positive side, that it will work out, that everything will be fine* (W9) *I avoid thinking about it as much as possible,* [...] *I also have a reason to show me that things must go on, I have a daughter, I have a son* (M9)

DISCUSSION

Studies point out the frequency of affective and sexual relationships between serodiscordant people, although they are unknown or ignored by society[6]. The prevalence of these relationships remains equally disregarded, while representing one of the main gaps in infection prevention, whether horizontal or vertical[11–12]. Clinical advances and health follow-up allowed the recognition of HIV infection as a chronic health condition, enabling people to plan their lives, such as the affective and reproductive[13]. However, there are barriers such as stigma, prejudice and discrimination against these couples[7]. Thus, this investigation stands out when contemplating relational, subjective, and individual aspects of serodiscordant couples regarding the experience of reproductive planning and pregnancy, which remain as challenges for the health care of this population.

Participants state not imagining a person without HIV infection accepting one who has it but point to serodiscordance as a factor that brings the couple closer due to companionship, especially during pregnancy. Therefore, the sexuality and reproduction of people living with HIV is a reality. However, the lack of dialogue, especially with health professionals, can lead to risky sexual behavior in an attempt to get pregnant[6]. The issues mentioned indicate the need to explore the intention of couples to become pregnant, in order to do so safely for both and according to their serological and clinical situation[2–3]. According to a systematic review of the general population of developing countries, male presence during prenatal care is associated with better maternal health outcomes[14].

When analyzing in the light of Heidegger's framework, it is possible to understand, from the manifestations of companionship, the characterization of the couple as a *being-with*. This way of being-*with* means *presence* and *concern* for the other, with whom one relates in the different possibilities of *daily* life. This relational way of being gives meaning to the life of the *being-human*[8]. In this *daily* effort experienced by the participants, the situation of serodiscordance is accepted, uniting both from the discovery of the serological situation, characterizing their meeting and opening to the possibility of *being-with*.

Thus, it is understood the importance of including the partner in prenatal consultations, as well as to share the treatment responsibilities, considering the positive impact of the partner's involvement in health care[5,15]. For Heidegger[8], this is living in the mode of *liberating solicitude*, which establishes a relationship of active care and considers the *existence* of the other, helping to become transparent to *himself*. The couple's acceptance of maintain the relationship in serodiscordant situation makes it possible to cope together the challenges, anxieties, conflicts, and fears related to social issues, such as prejudice and discrimination, and clinical issues, such as the fear of infection by the negative partner. These challenges highlight the need for care by a multiprofessional team with a view to comprehensive care[7].

In this study, pregnancy in a situation of serodiscordance was reported by the participants as something difficult, different from a normal pregnancy, and the couple keeps busy with it. For Heidegger, *occupation* is the way a person deals in the world with things around him, in his *daily life*, and what he faces in this world, called *instrument*, is what the *being occupies* with[8]. The couple *occupies* with treatment for the prophylaxis of vertical transmission of HIV during pregnancy

and after delivery, dealing with prenatal care in a specialized service and with the health follow-up of the child after birth. For this, they used the *instruments* that were at hand to conduct the routine of performing different tests, unknown in the previous pregnancy, and specific recommendations for food and other care for the child, such as medication intake and medical appointments.

The occupation of both men and women in daily care for adherence to treatment is configured as an important factor to prevent vertical transmission of HIV. Thus, the difficulties faced by women in communicating the diagnosis to their partners should be considered, due to the resistance of the last in taking the test. In Brazil, in 2019, the testing of pregnant women and their partners when entering the maternity hospital was included in the clinical protocol, expanding the testing and diagnosis of the partner and contributing to the minimization of this aspect of vulnerability to women and their babies[2].

By keeping *occupied*, the couple repeats what they heard about the care needed in this difficult *daily life* and seeks information to learn more about HIV, serodiscordance and pregnancy. Informed by these means, the couple performs an interpretation to understand what they know. For Heidegger, in certain phenomena, the *being* is in the *daily way of being* of speech, vision and interpretation, unveiling the *chatter*, *curiosity* and *ambiguity*[8].

In the *chatter*[8], the speech can be broad at the point that those who are listening do not really understand it. That is, a median and improper understanding, moving towards an *occupation* with what is spoken. This is present in the couples' statement, as they reported hearing from friends who are HIV positive and from health professionals about some care they need to have. But, in this way of *chatter*, they only repeat what was heard, for example "the need to take care of the CD4 and that before six months of life the child has the mother's antibodies".

In addition to what they hear about, the couple wants to know more and seeks information on this subject. Thus, *curiosity* is unveiled, which is shown as a structure of the constitution in *everyday life*[8]. *Curious*, they seek to make closer and known the *dis-tant* from themself, that is, what is not at hand in the *surrounding world*. *Curiosity* is occupied with providing new knowledge simply to get to know it and not to apprehend it[8]. The being-couple is shown in *curiosity* when they say they study and seek information about HIV to learn about the necessary care and to carry out the treatment correctly, talk to health professionals to find out what can influence in their health and in the child, such as the infection of the negative partner, the effects of treatment and the care for the child.

The *curiosity*, constantly renewed to not miss news, and *chatter*, a notion of understanding arising from "hear about", guarantee a deceptively *authentic* life for *being-in-the-world*. Faced with this claim, the *way of being* of *ambiguity* is unveiled, explaining the interpretation of what was seen and spoken in such a way as to *seem* that was understood when it was not done or not understood when it was done[8].

In *ambiguity*, *curiosity* takes care of knowing and the *chatter* of the discussion of what happens and, thus, everyone knows how to talk about what will happen. Thus, the entire discussion is presented as something *authentically* understood by the presence[8]. So, the being-couple shows up in *ambiguity* when they *seem* to understand that when getting pregnant in a situation of serodiscordance there is a safe prophylactic treatment, which protects the child from the vertical transmission of HIV, when, however, they did not understand, because prophylaxis does not guarantee their effectiveness in all cases. It is also *ambiguous seeming* not to understand when expresses the tension and *fear* of the child's HIV infection via vertical transmission, when has already understood the possibility of prophylaxis not being effective in all cases, even if it is done correctly.

The ontological connection between the phenomena of *chatter*, *curiosity* and *ambiguity* reveals the openness of *being-in-the-world* in its basic way of being in *daily life*, unveiling *decadence*. With this *way of being* is not intended to give a negative assessment of those who show themselves that way, but rather indicates that, in most cases, the *presence* is *together* and *in the world* of *occupations* and is frequently lost, *decays* in the *public* and *impersonal world*[8].

The *decadence* indicates the effort of *presence* in *coexistence* and tranquilizes, guaranteeing that everything is well and is right, because everything has already been spoken, seen, and interpreted. Tranquility, tempting, strengthens *decadence* and, assuming that it understands everything when it did not, moves the *presence* to an alienation of its most own *power-being*[8].

From this hermeneutic interpretation, it is understood that couples find in *decadence* the safety to experience the difficult daily life of pregnancy in the situation of serodiscordance. We understand reproductive planning as a strategy that can contribute to reducing insecurity, because, when performing it, the couple accesses safe information about the treatment of the woman and the baby, as well as guidance on not breastfeeding and using condoms to avoid sexually transmitted infections. Access to this guidance can authentically provide safety to experience pregnancy in the context of HIV. Moreover, another strategy to minimize the challenges faced is participation in groups in which they can share their anxieties[16].

Upon knowing the child's negative diagnosis, the couple is tranquilized by understanding that they are not responsible for the baby's illness or death. Alienated from *himself*, the being-couple attributes the effectiveness of the prophylaxis of vertical transmission to God and, while does not receive this divine grace, he remains imprisoned in *himself*, not opening himself to the possibility and *property* of living the joy of pregnancy. From this perspective, they do not recognize their effort as one of the main factors for the success of HIV VT prophylaxis, combined with overcoming the main barriers that negatively influence this result, such as non-adherence to treatment. According to a study developed in an African country, the involvement of men in actions to prevent vertical transmission of HIV is associated with the completion of treatment and the success of prophylaxis[17].

By revealing to live normally, couples seek to *level* their differences with others through *occupations*, doing what everyone does – working, having fun – as if the disease did not exist. In this *leveling*, the being-couple *moves away* from the *self* towards its *impersonally-self* to appear as everyone, those who do not live with HIV, are in the *public world*. In the *impersonal*, *together with the world* of *occupations*, the *presence* reveals in escape from its *own self* and from its most own *power-being*[8].

The *ways of being* of the *impersonal*, revealed by the *distancing* from *oneself*, by the *median* of *coexistence* in being with the other and by the *leveling* to *seem* like the others, constitute the character of the *public*. In it, things are obscured, making what was covered up as something *properly* known and accessible to all[8].

In the *impersonal*, the *being* is in a world common to *all*, in which the *being* let to be *himself* at the expense of being like others, in line with the *impersonal*[8]. They *listen* to what everyone *says* about HIV, about serodiscordance and make their understanding of prejudice. As a result, they *silence* their serodiscordant situation and elaborate their understanding of what is not said in *silence*[8]. They only speak about it among themselves, with the doctor and with a few family members. As a constitutive possibility of *speech*, *silence*, the couple is committed to *daily life* and does not reveal their serodiscordant situation to *live* with others without suffering prejudice.

In this *impersonal* way, the couple expresses hiding the HIV and serodiscordant situation due to prejudice. They hide their serological situation and their reproductive demands and needs from themself, others, and health professionals. The *participants' speeches* show the possibility of understanding in the face of *listening* and *silence*, both possibilities inherent to speech[8]. By hiding the situation, the couple unveil themselves in *silence*, engaging in *everyday* coexistence.

Couples also think about *speaking* to the child, when he is at an age where he can understand the parents' pronouncement about HIV, serodiscordance and about this context. However, they reaffirm the need to remain impersonal, thinking about the child's *coexistence* with others in the *public world*, as he can also suffer prejudice if the serological situation of the parents is known.

The *speech*, as an articulation of comprehensibility, come from the phenomenon of *listening*, in which *being-in-the-world* is *existentially* open as *being-with* others. In *listening*, the *being* has the possibility of reaching the phenomenon of *hearing*, in which the *way of being* of a comprehensive *listening* of what is *said* is unveiled[8]. In the interpretation for practice, it is understood that, from listening to this silence, professionals will be able to manifest the support demanded by the couple to maintain the silence of the serological situation. Listening and speaking are understood as important strategies in the care for this population based on the recognition of the essentiality of communication in the attention to the sexual and reproductive health of people living with HIV[18].

The couple presents in front of *itself* by revealing, with the event of pregnancy, its own *power-being* as a HIV serodiscordant couple, experiencing sexuality and reproduction in the same way as people who do not live with HIV. With the child's birth, who was not infected by the virus, the couple keeps their own *power-being* hidden, *decaying* in the world by running away from their *own self*.

The limitation of the study, which may interfere with the internal validity, is the sensitive nature of the theme, in which information bias cannot be excluded. So, to reduce the potentiality of this bias, the interviewer was trained in qualitative methods.

FINAL CONSIDERATIONS

We conclude that HIV serodiscordant couples get busy in usual activities, engage in having a life considered normal and keep silent about the diagnosis due to prejudice and stigma. The relationship between them and the child expresses the shared experience of reproductive planning and pregnancy as a way of support between the couple.

As a contribution to the health care for this population, it is necessary to recognize that people living with HIV can safely exercise their sexual and reproductive rights. It is also points out the need to recognize the couple as a unit of care, to break with the fragmentation of attention to reproductive issues in prenatal and childbirth services and to broaden the focus of care, so far restricted to women's and children's health.

In order to address the needs in the field of sexual and reproductive health of HIV serodiscordant couples, it is necessary to know the health needs of these couples before pregnancy, ensuring that they can do their reproductive planning. After pregnancy, it is recommended to combine the follow-up for prophylaxis of vertical transmission with the professional attitude of listening to the couple for the development of possibilities of care based on subjectivity.

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