

Original Article

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“I’m happy and terrified by the effective services of SUS”: beginning of PrEP

“Estou feliz e apavorado com o atendimento eficaz do SUS”: início da profilaxia pré-exposição

“Estoy feliz y aterrorizado con la atención eficaz del SUS”: inicio de la PrEP

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ABSTRACT

Objective: To understand the experiences related to the initiation and maintenance, during the first three months, of HIV pre-exposure prophylaxis (PrEP) at a Testing and Counseling Center

in a capital city in southern Brazil.

Method: Qualitative research, grounded in the interpretivist perspective. The setting was a Testing and Counseling Center. Twenty-eight individuals who initiated prophylaxis participated in the study. Data were generated between 2023 and 2024 using different techniques: semi-structured interviews, participant observation, and medical record review. Thematic content analysis was adopted.

Results: Prophylaxis was considered a strategy that enabled the individual management of HIV-related vulnerabilities. However, its effectiveness depends on the organization of healthcare service work processes and on the preparedness of health professionals to qualify access, strengthen therapeutic bonding, and ensure longitudinal care, in order to address multifactorial barriers that affect adherence.

Conclusion: Discontinuation was not configured as a homogeneous phenomenon and may be linked to organizational barriers, individual decisions, reconfigurations of the vulnerability context, or temporary clinical indications.

Descriptors: Pre-Exposure Prophylaxis; HIV/AIDS; Unified Health System; Qualitative Research.

RESUMO

Objetivo: compreender as experiências do início e da manutenção, nos primeiros três meses, da profilaxia pré-exposição ao HIV em Centro de Testagem e Aconselhamento de uma capital do sul do Brasil.

Método: pesquisa qualitativa, ancorada na perspectiva interpretativista. O cenário foi o Centro de Testagem e Aconselhamento. Participaram 28 pessoas, que iniciaram a profilaxia. A geração dos dados ocorreu no período de 2023 a 2024, por meio de diferentes técnicas: entrevistas semiestruturadas, observação participante e consulta ao prontuário. A análise de conteúdo do tipo temática foi adotada.

Resultados: a profilaxia foi considerada uma estratégia que possibilitou o gerenciamento individual das vulnerabilidades relacionadas ao HIV. Entretanto, sua efetividade depende da constituição dos processos de trabalho dos serviços de saúde, o preparo dos profissionais de saúde na qualificação do acesso, no fortalecimento do vínculo e no acompanhamento longitudinal, de modo a enfrentar barreiras multifatoriais que impactam a adesão.

Conclusão: a descontinuidade não se configurou como fenômeno homogêneo, podendo estar atrelada a barreiras organizacionais, decisões individuais, reconfigurações do contexto de vulnerabilidade ou indicações clínicas temporárias.

Descritores: Profilaxia Pré-Exposição; HIV/Aids; Sistema Único de Saúde; Pesquisa Qualitativa.

RESUMEN

Objetivo: Comprender las experiencias relacionadas con el inicio y el mantenimiento, durante los primeros tres meses, de la profilaxis preexposición al VIH en un Centro de Pruebas y Asesoramiento de una capital del sur de Brasil.

Método: Investigación cualitativa, anclada en la perspectiva interpretativista. El escenario fue un Centro de Pruebas y Asesoramiento. Participaron 28 personas que iniciaron la profilaxis. La generación de los datos ocurrió entre 2023 y 2024, mediante diferentes técnicas: entrevistas semiestructuradas, observación participante y consulta de historias clínicas. Se adoptó el análisis de contenido de tipo temático.

Resultados: La profilaxis fue considerada una estrategia que permitió la gestión individual de las vulnerabilidades relacionadas con el VIH. Sin embargo, su efectividad depende de la organización de los procesos de trabajo de los servicios de salud y de la preparación de los profesionales sanitarios para cualificar el acceso, fortalecer el vínculo terapéutico y garantizar

la atención longitudinal, con el fin de enfrentar barreras multifactoriales que afectan la adherencia.

Conclusión: La discontinuidad no se configuró como un fenómeno homogéneo, pudiendo estar vinculada a barreras organizacionales, decisiones individuales, reconfiguraciones del contexto de vulnerabilidad o indicaciones clínicas temporales.

Descriptores: Profilaxis Preexposición; VIH/Sida; Sistema Único de Salud; Investigación Cualitativa.

INTRODUCTION

Since the discovery of the human immunodeficiency virus (HIV) in 1981, more than 80 million people worldwide have been infected, and approximately 44.1 million have died from AIDS (Acquired Immunodeficiency Syndrome). Across the world, 40.8 million people were living with HIV at the end of 2024⁽¹⁾. Brazil ranks first among Latin American countries in HIV/AIDS cases⁽²⁾.

For more than a decade, Rio Grande do Sul state has stood out as the state with the highest prevalence of HIV and AIDS in Brazil; in Porto Alegre, approximately 1.64% of the inhabitants live with the virus. The epidemic is characterized as generalized⁽³⁾. This means that transmission is distributed homogeneously in the general population; an example of this is that the state capital has the highest HIV detection rates and the highest mortality rate among pregnant women, being 1.8 times higher than the national average⁽²⁾.

Pre-Exposure Prophylaxis (PrEP), in Brazil, has been identified as a fundamental and powerful strategy among the items of combined prevention for controlling the HIV/AIDS epidemic, being an opportunity to change the context of HIV prevention and offering a new protection option⁽⁴⁾. This proposal foresees the use of antiretroviral medications by HIV-negative individuals, to prevent future infection⁽⁴⁾. Its implementation within the Unified Health System (*Sistema Único de Saúde* - SUS) was possible after the execution of research such as PrEP-Brazil and the Combina Study, in 2018, in specialized services of the Brazilian public healthcare network⁽⁵⁾.

PrEP is an antiretroviral medication that can be used daily or on demand. The Clinical Protocol and Therapeutic Guidelines for PrEP indicate a 95% reduction in HIV incidence with regular use⁽⁴⁾. In 2022, the indication criteria were updated for sexually active adults and adolescents vulnerable to HIV infection, expanding its access⁽⁴⁾.

Regarding HIV infection, it is also pertinent to present the concepts of vulnerability and risk. Vulnerability is neither a personal condition nor a human characteristic, but rather the consequence of a given condition – generally an environment that unfairly restricts or prevents

the development of one or more aspects of life, placing the individual in a vulnerable situation with a greater risk of having their rights denied. Some specific situations of vulnerability may be related to age, race/color, sex, sexual orientation, economic condition, origin, physical characteristics, and cultural or political circumstances⁽⁶⁾. Risk, from an epidemiological perspective, refers to the establishment of causal relationships between different exposures and health outcomes, indicating the probability of an event in the observed population⁽⁷⁾. In turn, the concept of vulnerability encompasses that of risk by including the individual-collective dimension and the interferences occurring at different levels, both in exposure and in susceptibility to a health issue⁽⁸⁾.

Structural and sociocultural factors, such as poverty, low income, educational inequalities, racism, violence, and sex work, have been identified as determinants for not initiating, not adhering to, or discontinuing PrEP^(9,10). Studies also report difficulties in the inclusion of sex workers, transvestites, and transgender women, while users' concerns regarding short- and long-term health effects, self-perceived risk of acquiring HIV, limited awareness, and social stigma contribute to discontinuation^(11,12). The abandonment and interruption rates of follow-up among individuals who started using prophylaxis in Rio Grande do Sul in 2024 totaled 32% (n=2,269)⁽¹³⁾.

It is believed that understanding the similarities and differences in experiences with PrEP across all social groups, considering the intersection of barriers and the way prophylaxis is accessed, can influence experiences and continuity of use⁽¹²⁾. Therefore, the objective of this study is to understand the experiences of beginning and maintaining PrEP during the first three months at a Testing and Counseling Center in a capital city in southern Brazil.

METHOD

This is a qualitative research, supported by an interpretative perspective. Qualitative research explores the universe of meanings, motives, attitudes, beliefs and values of the people involved in the phenomenon under study⁽¹⁴⁾. The interpretative perspective seeks to access the interpretations of specific social groups based on their lifestyles and ways of expressions⁽¹⁵⁾.

The study was conducted at the HIV Testing and Counseling Center (HTC) in a capital city in southern Brazil. Recognized as a reference service for the entire population, the HTC offers various prevention strategies, such as rapid HIV testing, Pre-Exposure Prophylaxis (PrEP) and Post-Exposure Prophylaxis (PEP).

The initial approach to participants took place in person at the HTC. At the time of inclusion in prophylaxis, all people receiving care were invited to participate in the study,

consecutively. For three days a week, over a period of 60 days, from December 15, 2023, to May 18, 2024, data generation took place. The participants and the researcher did not know each other previously. Initial contact occurred during the invitation to participate, when participants were informed that the interviewer, a nurse and master's student, was part of a research team interested in understanding aspects of pre-exposure prophylaxis.

A total of twenty-eight individuals participated in the first interview, considered as the baseline moment. The inclusion criteria were: age over 18 years; scheduled appointment at the service for initial use of PrEP; and a telephone with an active line for contact. There were no exclusion criteria. Six users decided not to participate, two did not meet the eligibility criteria because they did not have a contact number and were under state guardianship (FASC), and one participant withdrew their consent after the first interview. The number of participants was guided by the “power of information,” considering, for the study objective: sample specificity, theory, quality of dialogue, and analysis strategy⁽¹⁶⁾.

The interviews were conducted by the main researcher (baseline moment), based on a semi-structured script in two stages. In the first stage, the interviews were conducted in person at the HTC, in a private room, only for the researcher and participant, in order to maintain a comfortable and safe environment, in an estimated time of 30 minutes (Chart 1). The instrument had 11 questions; In addition to sociodemographic characterization, data regarding access, initiation of prophylaxis, motivation, and experiences related to care were considered. Participant observation was carried out from the moment the participant arrived until the medication was dispensed, focusing on aspects of access and reception. Participant observation allows the researcher to use the sociocultural context of the observed environment to obtain an in-depth understanding of a particular theme or situation through the meanings attributed to the phenomenon by the individuals who live and experience it⁽¹⁷⁾. A field diary was used to record experiences throughout the data collection process.

Chart 1- Contacts and interviews of research participants at baseline, at 30 days and at 90 days. Porto Alegre, RS, Brazil, 2024.

Contacts and interviews with research participants at 0, 30 days, and 90 days					
Baseline	Interviewed Participants	Sought PrEP	Discontinued PrEP	Did not respond to telephone contact attempts	Observations

	28 individuals (In-person)	28 initiated use	-	-	Three opted for on-demand PrEP; 25 opted for daily PrEP
30 days	22 individuals (In-person or Telephone)	24 maintained use	4 discontinued use	6 did not answer telephone contact attempts	Medical records of the six individuals who did not answer the phone were reviewed to verify follow-up and PrEP dispensing.
90 days	22 individuals (telephone contact)	22 maintained use	6 discontinued use	8 did not answer telephone contact attempts	Medical records were reviewed to verify follow-up and PrEP dispensing for the eight individuals who did not answer the phone.

Source: Research data, 2024.

Subsequent interviews, referring to the 30- and 90-day timeframes (Chart 1), were semi-structured, with 10 questions about maintenance, medication use, and follow-up appointments. The questions were asked by the main researcher via cell phone, and the responses were recorded on a digital device with prior authorization from the interviewees. The average call duration was 25 minutes. Notes were taken during the calls. If the call was not answered after three attempts at different times within a one-week period, the electronic medical record was consulted at the HTC to determine if the user had collected the medication. Maintenance was ensured by information regarding medication dispensing; discontinuation was confirmed when there was no record of withdrawal or reason for interruption in the medical record. No pilot test was conducted at any stage. Despite this, the first five interviews were assessed regarding comprehension of the questions and topics presented, and no modifications were necessary. The interviews were transcribed using the Transkriptor®⁽¹⁸⁾ No interview needed to be repeated.

Thematic content analysis was used⁽¹⁴⁾ respecting its stages: pre-analysis, material exploration, treatment of the obtained results and interpretation. The fully transcribed interviews were imported in .docx format into the Nvivo® software⁽¹⁹⁾ and coded independently by two researchers. Each participant was identified by an alphanumeric code (e.g., A1, A2, A3) in order to preserve anonymity. Subsequently, in-depth reading with open coding was performed, in which relevant excerpts from the speeches were highlighted and assigned to

nodes in NVivo®⁽¹⁹⁾. These nodes represented units of meaning, defined as textual segments expressing perceptions, experiences, and meanings related to knowledge, initiation, and maintenance of PrEP. Approximately 112 meaning nodes were identified. For example, the statement “I failed to use condoms in those exposures, so PrEP comes more as an extra protection” was coded in the initial node “motivation for starting PrEP”. The statement “I had difficulty taking the pill” was allocated to the node “difficulties in adherence”.

The analysis was conducted interactively, with systematic discussions between the two coders. Disagreements identified during the coding and categorization process were debated until consensus was reached, contributing to analytical rigor and interpretative consistency of the findings. After in-depth reading and classification of the statements, the units to be referenced by themes were selected and grouped according to convergence of ideas⁽¹⁴⁾, gave rise to the three categories: “Knowing PrEP: dissemination and access”; “PrEP as extra and biotechnological protection”; and “Experiences in maintaining PrEP at 30 and 90 days”.

The research design did not foresee the returning of transcripts to participants for comments or corrections, with the researchers arbitrarily making this decision. In addition, the longitudinal follow-up with three interview periods allowed for in-depth analysis and confirmation of meanings throughout the process, contributing to the interpretative consistency of the findings. To ensure and guide the research, the recommendations of the Consolidated Criteria for Reporting Qualitative Research (COREQ)⁽²⁰⁾ were followed.

The ethical aspects of the study were respected in compliance with the Guidelines and Regulatory Standards for Research Involving Human Beings, of Resolution No. 466/2012 of the National Health Council of the Ministry of Health⁽²¹⁾. The research was submitted to and approved by two Research Ethics Committees, under the numbers CAAE No.: 73048923.4.0000.5347 and 73048923.4.3001.5338. All participants previously signed the Informed Consent Form (ICF).

RESULTS AND DISCUSSION

A total of 28 individuals participated in the study (Chart 2), aged between 20 and 57 years, with a mean age of 30 years. Regarding gender identity, 25 participants identified as cisgender men, two as transgender women, and one as a cisgender woman. As for sexual orientation, 21 identified as homosexual, five bisexual, one pansexual, and one heterosexual. Regarding race/ethnicity, 23 self-identified as White. The majority had 12 or more years of schooling (n=26) and reported marital status as single (n=25).

Chart 2- Characteristics of participants who initiated PrEP. Porto Alegre, RS, Brazil, 2024.

Name	Age	Race/ Color	Gender	Sexual Orientation	Education Level	Marital Status
A01	35	Black	Cisgender Man	Homosexual	12 years or more	Single
A02	20	White	Transgender Woman	Pansexual	12 years or more	Single
A03	37	White	Cisgender Man	Homosexual	12 years or more	Married
A04	26	White	Cisgender Man	Homosexual	12 years or more	Single
A05	26	White	Cisgender Woman	Bisexual	12 years or more	Single
A06	21	White	Cisgender Man	Homosexual	4 to 7 years	Single
A07	23	White	Cisgender Man	Homosexual	8 to 11 years	Single
A08	23	White	Cisgender Man	Homosexual	12 years or more	Single
A09	29	White	Cisgender Man	Homosexual	12 years or more	Single
A10	35	Black	Cisgender Man	Bisexual	12 years or more	Married
A11	30	White	Cisgender Man	Homosexual	12 years or more	Single
A12	24	White	Cisgender Man	Homosexual	12 years or more	Single
A13	40	Brown	Cisgender Man	Homosexual	12 years or more	Single
A14	40	White	Cisgender Man	Homosexual	12 years or more	Single
A15	20	White	Cisgender Man	Homosexual	12 years or more	Single
A16	24	White	Cisgender Man	Bisexual	12 years or more	Single
A17	32	White	Cisgender Man	Homosexual	12 years or more	Single
A18	39	White	Cisgender Man	Homosexual	12 years or more	Single
A19	47	White	Cisgender Man	Homosexual	12 years or more	Single
A20	28	White	Cisgender Man	Homosexual	12 years or more	Single
A21	29	White	Cisgender Man	Homosexual	12 years or more	Single

A22	23	White	Cisgender Man	Homosexual	12 years or more	Single
A23	27	Brown	Cisgender Man	Homosexual	12 years or more	Single
A24	44	White	Cisgender Man	Homosexual	12 years or more	Single
A25	26	White	Cisgender Man	Homosexual	12 years or more	Single
A26	37	White	Cisgender Man	Bisexual	12 years or more	Single
A27	53	White	Transgender Woman	Heterosexual	12 years or more	Divorced
A28	21	Yellow	Cisgender Man	Bisexual	12 years or more	Single

Source: Research data, 2024.

During participant observation⁽¹⁷⁾ conducted at the HTC, a structured and functionally organized physical environment was observed for conducting HIV testing, counseling, and offering prophylaxis. The presence of a waiting area with chairs and informational materials about sexually transmitted infections (STIs) and prevention methods demonstrates a concern with health promotion. Initial care takes place through two acrylic windows at the reception desk, where users register and receive guidance.

However, one of the problems identified in the physical space layout is the lack of distance between the waiting chairs and the reception area and communication area. This proximity compromises the confidentiality of the initial interactions and may expose users to embarrassing situations, especially in a service dealing with sensitive information related to sexual health. This reveals the importance of rethinking the layout of the environment to ensure greater privacy and respect for confidentiality from the first contact with the service. The consultation rooms, located in the inner area, are private and ensure the confidentiality necessary for reception and individual counseling.

Beyond the structure, the dynamics of access to services reveal inequalities and issues of social visibility. It was identified that, at the HTC, most users are White men, while at the Specialized Care Service (SCS), responsible for continuous care for People Living with HIV (PLHIV) and located next to the HTC, Black people of both genders predominate. This distinction between the profiles attended in each service raises an alert about the way in which social markers, such as race and gender influence access, the search for care and the very perception of HIV-related risk.

In conversations with HTC professionals, concern emerged regarding the discrepancy between the profile of users attended and the profile socially understood as more susceptible to HIV. This perception points to possible structural barriers affecting access to prevention services⁽¹²⁾ or groups historically more exposed to risk, such as Black women, peripheral populations, and transgender people. These findings indicate the need for strategies that broaden the reach and equity of service provision to effectively address the different vulnerability profiles present in the territory.

The empirical findings are presented below, organized into three analytical categories.

Knowing PrEP: dissemination and access

Participants approached prophylaxis in different ways, and it is noteworthy that they reported more than one source of information. Below, in Chart 3, the statements are presented illustrating the initial contact and starting point regarding the sources of information through which participants learned about pre-exposure prophylaxis.

Chart 3- Sources of information about PrEP. Porto Alegre, RS, Brazil, 2024.

Sources of information	Interviewees' Statements
Friends (mentioned by 18 participants)	<i>I learned about PrEP from friends, through recommendations. They started using it and talked about it, mostly for the safety benefit. (A18)</i>
Internet (mentioned by 15 participants)	<i>I searched on Google, I've known about it for a while, but only now have I decided to look into it and start taking it. I work in prostitution, and I already knew about it because one of the girls at the club already takes it. (A05)</i>
Partner (mentioned by eight participants)	<i>I first heard about it from the boy I had unprotected sex with. Then, I was worried if he had transmitted something to me, and [...] and he said he was taking PrEP. He explained what it was. (A02)</i>
Transgender Clinic/ Healthcare Professionals (mentioned by six participants)	<i>I heard about it at the transgender clinic and thought about doing it. (A27) Actually, I already had my hepatitis B treatment here, so I spoke with the doctor, and he referred me. (A22)</i>
PEP Use (mentioned by four participants)	<i>I had a situation about two years ago where I needed to take PEP, and that's how I learned more about PrEP. Since I had been having difficulties using condoms with multiple partners for some time, I decided to start now. (A13)</i>
Leaflet (mentioned by one participant)	<i>I think it was at a pride parade, but it was through a leaflet that I learned about PrEP. (A10)</i>

Source: Research data, 2024.

It is noticeable that the discovery about PrEP occurred through exchanges of information with people with affective and/or sexual bonds, among close friends, or via digital media platforms. Studies⁽²²⁻²³⁾ highlight the role of peer social support and its association with higher rates of knowledge and adherence to prophylaxis, as well as a reduction in the negative effects of stigma and discrimination. There appears to be little involvement of traditional health institutions in disseminating content related to PrEP. However, the Transgender Clinic has promoted combined prevention strategies, considering the presence of two transgender women linked to the institution. This makes it possible to discuss the ways in which dissemination occurs, as reflected in the following statements:

I think that this issue of pre-exposure prophylaxis is also poorly publicized. That's why it took me so long to seek care. (A24)

"[...] there is very little information available, but, we have to go after it and find out. Going after it is easy, but I don't see it coming to you. (A18)

There is a challenge in dissemination, regarding the evidence that the demand for PrEP is concentrated only among gay and bisexual men with high/medium income and higher education⁽²³⁾, with reduced demand among populations equally vulnerable to HIV, such as transgender and cisgender women, sex workers, and gay men with lower educational attainment. Participants emphasized that they miss broader dissemination through general media and information conveyed in language accessible to all audiences, avoiding the explicit labeling of high-risk groups and thereby reducing prejudice. Users' concerns regarding this issue are evident:

There is little dissemination about PrEP, even after so many years that it has been in effect for people, because I talk to my work colleagues [...], and most don't know that PrEP exists! Most say to me: what is that? Are you on HIV? Did you inject yourself? I have to say, "no, this is an HIV contraceptive." That's the only way people can understand what it is, so I think there needs to be more publicity, PrEP campaigns, because there's a significant lack of dissemination and understanding among the general population. (A15)

It is observed how complex and controversial this dissemination pattern is, especially regarding the inclusion of gender identities and sexual preferences within eligibility criteria, differing from the predominant heterosexual norm. This construction developed over a long period and reinforces the stigma surrounding certain population groups, in addition to perpetuating the erroneous idea that only people who fit heteronormative standards are exempt from the risk of acquiring HIV and, therefore, do not meet the criteria for PrEP⁽²⁴⁾.

The possibility of HIV infection is not limited to certain social groups; however, vulnerabilities are structural and produce inequities, reflecting historical structures of racism, sexism and socioeconomic inequality. In official data, in 2022, the predominance of the exposure category of men who have sex with men (MSM) was observed in the Southeast (49.8%), Midwest (47.5%), and Northeast (34.8%) regions, while in the North (48.5%) and South (45.9%) regions the predominance was of the heterosexual category⁽²⁾. However, even with these data, and despite changes in eligibility criteria, there is still little dissemination of these changes, which does not ensure that all groups have adequate access to HIV prevention⁽⁴⁾. Dissemination will not only reduce the stigma associated with HIV, but will also promote equity and justice in health, including all those who wish to use prophylaxis.

Historically, the Black population has accounted for the highest number of AIDS-related deaths in the country⁽²⁾. It is important to pay attention to the results and discussion presented, focusing on the possible social mechanisms that cooperate and act with the matrices of oppression. It is necessary to reflect intersectionally, considering that issues such as race/color, class and gender are interconnected⁽²⁵⁾, that is, it is relevant to assess how these characteristics of individuals interfere with access to and adherence to health care. It should be remembered that societal change depends on non-discriminatory, non-prejudiced and anti-racist practices as part of a structure⁽²⁶⁾.

The challenges associated with access to PrEP, including the distance between home or workplace and the healthcare service, considering travel time and transportation costs, were discussed during the interviews and were shown to influence the initiation of prophylaxis. In summary, most participants (n=22) either lived or worked near the HTC.

PrEP as an extra and biotechnological protection

After learning about the possibility of preventing HIV, participants expressed the reasons that led them to start using prophylaxis: having unprotected sexual relations, repeated use of PEP, fear of contracting HIV, serodiscordant relationship, being single, open relationship, and being a sex worker. The main feeling attributed to PrEP was “protection,” but in varied contexts, ranging from “extra security” when used concomitantly with other prevention methods, such as condoms, to reducing fear and concern after unprotected sexual intercourse, as illustrated in the following statements:

The fact that I had more risk exposures in the last year, I had three exposures over the course of a year, which, for me, is quite a lot. In that case, I failed with the

condom in those exposures, so PrEP comes more in the sense of having extra protection for situations where I can't use a condom for some reason. (A08)

Because I'm a person who really tries to use condoms in my relationships, but I have to exercise a lot of self-control, because many times I don't want to use them, and afterward I become very paranoid because I know I exposed myself. I think it will be safer in those cases. (A02)

It was observed that the most frequent responses to the question regarding methods of protection against HIV were PrEP and condoms. PrEP is driving a shift toward greater medicalization, emphasizing the importance of treatments and biomedical interventions in the management of HIV and AIDS. This suggests that attention may be diverted from other important dimensions, such as the social, cultural, and community aspects of health⁽²⁷⁾. Although PrEP is perceived as an effective protection strategy, the reports do not address in depth the structural dimensions of risk, such as racial inequalities or barriers to access to healthcare services. This asymmetry suggests that prevention is often understood within an individual context, which calls for attention to the incorporation of intersectional approaches in healthcare delivery. A regression can be perceived in this more biomedical- and technology-centered perspective, similar to the predominant approach during the early years of the epidemic outbreak in the 1980s^(27,28). The biomedicalization of prevention, prejudice, stigma, and the rise of conservatism undermine the Brazilian response to AIDS⁽²⁹⁾.

The challenge now is to understand how new technologies will respond to the epidemic and, furthermore, to consider HIV/AIDS in its entirety, with significant implications for prevention, education, and care⁽²⁹⁾. The SUS, in Brazil, plays a fundamental role in prevention and health promotion, highlighting the incorporation of different actions in response to the specific needs of certain populations and certain forms of HIV transmission, based on the National Guidelines for Combined HIV/AIDS Prevention⁽⁴⁾. Participants positively evaluated the inclusion of this prevention resource in the SUS, as can be seen in the following statement:

It's great that PrEP is available in the SUS. I'm happy and terrified by the effective services of SUS. I had no idea it was so effective. (A19)

It is important to consider each individual as unique within their social, cultural, and personal context when dealing with health-related issues. It is recognized that each person has their own experiences and circumstances influencing their well-being, making it necessary to personalize health interventions in order to meet each individual's specific needs, empowering them and promoting autonomy in healthcare⁽⁴⁾. In addition, the service needs to have this individual perspective because it generates benefits for the collective.

Thinking about the widespread HIV epidemic, some groups present greater vulnerability in their sexual lives, such as women who have little or no basic knowledge regarding HIV/AIDS prevention, with prevention being mainly associated with condom use⁽³⁰⁾. According to Foucault⁽³¹⁾, romantic love is more present in women's imaginaries than in men's, distinguishing norms of emotional conduct and indicating a cultural commitment supported by the repression of female sexuality, as observed in the following statement:

Because, since I have a partner who is heterosexual, so he has always had relationships with women, he never wanted to use a condom, he never wanted to. I always say that we have to trust our partner, but I trust and distrust, especially when it comes to sex. I know it shouldn't be like this. (A27)

It is necessary to universalize and guarantee full access for all individuals who wish to use and need combined HIV prevention methods. Raising awareness among healthcare professionals regarding the population's rights and the provision of comprehensive care within the SUS service network for the general population is of great importance⁽⁴⁾. An example of this is a situation of vulnerability in which specialized access would be fundamental for care:

I just think there could be a 24-hour place, because in the times I needed PEP, for example, I was very badly treated in other places. They treat us like: "ah, if you did...", even when I was sexually abused, so now you have to be mistreated, they don't explain properly. So, it would be nice to have a place like this that welcomes and is specialized in this, operating on Saturdays and Sundays, emergency hours. They should expand this access, more because of the hours. (A05a)

There is concern regarding healthcare services that provide access to HIV prevention, as they may be susceptible to programmatic cuts or are often limited in their scope and capacity⁽²²⁾. For example, they may focus on conducting risk assessments and providing basic interventions such as condom distribution and HIV testing. However, this may not be sufficient to address deeper issues related to stigma and prejudice surrounding HIV⁽²²⁾, as making it crucial that healthcare services receive adequate resources not only to provide interventions across a wide range of aspects^(10,24).

Experiences in maintaining PrEP at 30 and 90 days

Follow-up consultations occur periodically, and after starting medication, users undergo their first assessment within 30 days and then, if stable, every 90 days. Closer follow-up may be necessary in cases of STI symptoms, adverse medication events, or changes in follow-up tests results⁽⁴⁾.

Understanding the pharmacotherapeutic care process and decision-making for initiating prophylaxis involves a series of factors, such as the assessment of perceived benefits, side

effects, personal beliefs about health and illness, and previous experiences with medications, among others⁽³²⁾. Participants perceived improvements in quality of life when using PrEP, reflected in the sense of security and peace of mind associated with prophylaxis use. This perception is illustrated in the following statements:

It adds a sense of security regarding the sexual aspect between me and my boyfriend. Since we are a serodifferent couple, we now feel more at ease. I already felt that way before, but for him, I can see that he feels much safer. It seems like he relaxed a little more. (A22)

Thus, it gave me more peace of mind, a feeling of security. Less worry if some unprotected sexual act happens. (A01)

One of the factors presented as facilitating the daily use of PrEP is that the user already takes other medications in their routine. In contrast, a barrier to the continuity of prophylaxis in Brazil, according to studies⁽¹⁰⁾, is characterized by the difficulty of incorporating medication into daily routines, and some participants pointed to this reason as one of the determinants for not using PrEP.

As I told the doctor, I had problems taking pills. I am someone who occasionally takes paracetamol for headaches, it is uncomfortable having to take medication. (A09)

I don't like taking medicine. If I could avoid taking it, I wouldn't, but it's not just that, there are risks. (A12)

Thus, a comprehensive approach to pharmacotherapeutic care requires careful consideration to find ways to support individuals in decision-making processes that should be informed and aligned with their needs. The complexity of the decision-making process is acknowledged⁽²⁹⁾, since it may reflect individual experiences, concerns, and preferences. Shared decision-making can be exemplified in participant A03's statement, who discussed the possibility of using on-demand PrEP with the healthcare professional at the beginning of prophylaxis:

I found it practical because it's not every day, and I didn't see the need for that, but maybe it would be easier if it were daily, so I'm still thinking about it... It's actually something to discuss with the doctor when I return, because she's giving me more time to see whether I prefer it this way or whether it's better to take it every day. (A03)

However, this shared decision may not happen, as in the case of the participant who did not want to initiate prophylaxis. However, after two presentations, the professionals convinced him, and he used PrEP, but only for three weeks:

Well, I don't like taking medication. But this specific one, I don't know, I don't want to, I don't like taking this type of medication because I think it gives me more freedom." It's as if I should do something, since I'm taking the medication, it kind of

gives me more freedom to have risky relationships; it's a security, but it's not a security that I find good or positive. (A12)

This statement highlights the importance of considering individual behaviors and sexual health practices when implementing prevention strategies. Studies indicate that there is no true correlation between PrEP use and risk compensation⁽³³⁾. On the contrary, prophylaxis use may increase protection against infection, regardless of the systematic use of condoms. Individuals who already use condoms may further increase their protection by adding PrEP to their routine. On the other hand, those who do not regularly use condoms in their sexual practices are unlikely to begin using them in association with prophylaxis. Another issue perceived in the reports concerns paradigms related to risk exposure and prophylaxis:

I remain very terrified and scared because people tell me that, because I now take PrEP, I don't need to use condoms anymore. So, I go to an environment where people have sex, and I see this situation, the limited use of condoms, with this report of PrEP use, but, like all reports, it's self-reported, there's no way to trust it. (A10)

There are several challenges that the provision of PrEP requires, therefore, special attention must be given to continuity, both to develop strategies that strengthen bonds with healthcare services and to identify more vulnerable individuals and support them in the daily use of the medication. Counseling, together with welcoming care, is fundamental for maintenance⁽⁴⁾. Issues related to privacy and quality of care ensure that users feel supported and protected when seeking this HIV prevention resource. Feeling comfortable within the service environment was a topic discussed and was identified as either a facilitator or a barrier in several statements:

Wonderful, I thought it was sensational. I think the great advantage is this follow-up, having frequent check-ups, having ongoing guidance. Scheduling appointments is easy, having the tests done within the network is also great, I've always been seen at my scheduled times. In short, I have nothing to complain about, on the contrary, I'm finding the service wonderful. (A13)

Regarding the service provided to people, I think this part should be more confidential and protect certain things; for example, the receptionist, that glass in front of her prevents us from speaking in a normal or low tone voice. (A15)

Furthermore, the information provided by professionals needs to be easy to understand, using short sentences and reviewing the main points at the end of the conversation by asking what the person understood. When this does not occur, it may lead to distrust or to a decision not to use prophylaxis due to lack of understanding. These experiences, reported since the beginning, with four cases of discontinuation after 30 days and six up to 90 days, provided

specific data, mainly regarding the reasons for PrEP discontinuation, presented in the chart below.

Chart 4- Discontinuation and reasons among PrEP users. Porto Alegre, RS, Brazil, 2024.

PrEP maintenance after 30 days: 24 participants using PrEP PrEP maintenance after 90 days: 22 participants using PrEP			
Participant	Discontinuation after 30 days	Discontinuation after 90 days	Reason for discontinuation
A02	Discontinued	Returned to use	Barriers related to service hours and conflicting information from the healthcare team. After the second month, managed to obtain prophylaxis despite difficulties in access.
A04	Maintained use	Discontinued	End of the open relationship arrangement.
A06	Discontinued	Discontinued	Moved to another Brazilian state; has not accessed the service so far.
A08	Maintained use	Discontinued	Recovering from hepatitis A and not using PrEP due to medical advice.
A09	Maintained use	Discontinued	Moved to another country, no access to the service at the moment.
A12	Discontinued	Discontinued	Difficulty with daily adherence and perception of lower risk (risk compensation)
A27	Discontinued	Discontinued	Hormonal problems, emotional difficulties, and marital issues.

Source: Research data, 2024.

The experiences demonstrate the facilitators and barriers to maintaining PrEP in daily life and may vary from one individual to another. Of the 28 participants, six discontinued use within the first three months. The main facilitators reported during the interviews were the welcoming approach of the SUS team, ease of scheduling appointments, regular health follow-up with laboratory tests, free healthcare services, the proximity of the HTC to participants' homes or workplaces, and the feeling of being more protected. This demonstrates that the SUS,

when properly implemented, fulfills its role in promoting access, comprehensiveness, bonding, and continuity of care^(4,34), especially in strategic services, such as Testing and Counseling Centers, which play an important role in the prevention and control of STIs.

Regarding the barriers, the following were pointed out: lack of service hours beyond regular business hours; ineffective communication among teams in accessing prophylaxis; stigmatized dissemination; stigma related to HIV and PrEP; risk compensation; and the need for daily medication use. Some of these barriers have already been described in the literature^(9,10,12), in situations that contribute to prophylaxis interruption, such as HIV infection diagnosis; the individual's desire to stop using the medication; changes in life context with a significant reduction in the frequency of sexual practices involving potential risk of infection; and persistence or occurrence of relevant adverse events^(9,12).

Studies indicate that the social determinants of health are important predictors of racial and ethnic disparities in PrEP adherence^(9,10,35). Another study analyzed PrEP discontinuation during a climate emergency in a capital city in southern Brazil and reported interruptions in access to medication, failures in institutional communication, and feelings of insecurity regarding continuity of care as contributing factors to the discontinuation of prophylaxis use⁽³⁶⁾.

This study presents some limitations that should be considered when interpreting the findings: a) the participant profile, predominantly composed of cisgender White men with high educational level, may not reflect the diversity of populations more vulnerable to HIV, such as Black women, peripheral populations, and transgender people experiencing greater social exclusion. This composition may have influenced the reported experiences, restricting the range of perspectives analyzed; b) the operational definition of discontinuation was based on the absence of medication dispensing records in medical charts or on self-reported interruption, which may not capture nuances such as planned temporary pauses, care transitions to other services, or strategic changes in prophylaxis use; c) follow-up limited to the first 90 days allowed understanding of the initial experience with PrEP, but did not make it possible to assess medium- and long-term maintenance, nor to identify sustained patterns of adherence or interruption; d) the decision not to return the transcripts to participants may be considered a limitation from the perspective of collaborative validation. However, conducting interviews at three different time points contributed to deepening and consolidating the meanings produced throughout the investigative process.

FINAL CONSIDERATIONS

The study made it possible to understand the experiences related to the initiation and maintenance of PrEP in the first three months of use at a Testing and Counseling Center in a capital city in southern Brazil, highlighting factors that directly influence adherence to the strategy. The findings demonstrate that access to PrEP is permeated by multifactorial barriers, highlighting difficulties related to service organization, service hours, and limited dissemination of information about the locations where prophylaxis is offered. These elements affect both the initial decision to use PrEP and its continuity, indicating the relevance of improving institutional workflows, reviewing the availability of schedules, and strengthening communication strategies that expand access and promote users' continuity in care.

The availability of PrEP through the Unified Health System (*Sistema Único de Saúde*) represents a significant expansion of HIV prevention strategies in the country. However, access to information and services remains concentrated within a specific user profile, highlighting the need to broaden dissemination throughout the public healthcare network, including Primary Health Care, with approaches that do not reinforce stigmas and that consider practices, contexts of vulnerability, and social markers such as race/color, gender, and class, articulating interventions at the individual, community, and structural levels.

The analysis of interruptions revealed that discontinuation is not a homogeneous phenomenon, assuming distinct forms — related to organizational barriers, individual decisions, changes in risk context, or temporary clinical indications. This differentiation contributes to improving the understanding of therapeutic continuity and reinforces the importance of systematically recording the reasons for interruption during follow-up, enabling responses that are better adapted to the specificities of each situation, whether through the reorganization of care workflows, the strengthening of shared decision-making, clinical follow-up, or care-transition strategies in situations of territorial mobility.

Larger-scale studies that delve deeper into the intersections between class, gender, and race/color may broaden the understanding of inequalities in access to and continuity of PrEP, contributing to the improvement of public policies and the organization of more equitable practices in addressing HIV/AIDS, especially in regions historically marked by high epidemic rates.

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Data and material availability

Access to the dataset may be granted upon request to the corresponding author to ensure the protection of participant confidentiality and the ethical use of information. This measure allows for the evaluation of the purpose of the request and ensures that data sharing occurs responsibly, in compliance with the ethical and regulatory guidelines applicable to research.

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