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REASONS RELATED TO THE DELAYS FOR THE START OF HIV / AIDS TREATMENT

MOTIVOS ASSOCIADOS AO ATRASO PARA O INÍCIO DO TRATAMENTO DE HIV/AIDS

MOTIVOS ASOCIADOS AL RETRASO PARA EL INICIO DEL TRATAMIENTO DE VIH / SIDA

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ABSTRACT

Objective: to identify the reasons associated with the delay in starting treatment of patients living with HIV / AIDS. ***Method:*** this is a qualitative, descriptive, cross-sectional study of 31 patient charts in the treatment gap listing in the Ministry of Health's SIMC system, with statistical analyzes performed by SPSS software. ***Results:*** it is inferred that the treatment gap of the municipality between August and December 2017 was 21.7%, and in 2018 it was 78.3%; of these, 21 patients were in the situation of abandonment of ART and 22 patients in the gap situation due to other outcomes. ***Conclusion:*** it was concluded that there was a 360.87% increase in the treatment gap between people living with HIV / AIDS between 2017 and 2018, and that the associated factors and causes were refusal of treatment, abandonment of ART, death and miscellaneous outcomes. It should be noted that the study did not show any significance regarding the clinical condition, marital status, socioeconomic status and treatment abandonment, and that the huge gaps in treatment coverage, stigma and discrimination continue to impair the effectiveness of responses. ***Descriptors:*** Refusal of treatment; HIV / AIDS; Follow-up of Health Care; Outpatient Health Services; Patients who abandon treatment; Patient Monitoring.

RESUMO

Objetivo*:** identificar os motivos associados ao atraso para o início do tratamento de pacientes vivendo com HIV/Aids. ***Método*:** trata-se de um estudo qualitativo, descritivo, transversal, realizado com 31 prontuários de pacientes na listagem de *gap* de tratamento, no sistema SIMC do Ministério da Saúde, com análises estatísticas realizadas pelo *software* SPSS. ***Resultados*:** infere-se que o *gap* de tratamento do município, entre agosto a dezembro de 2017, foi de 21,7%, e, em 2018, foi de 78,3%; destes, 21 pacientes se encontravam em situação de abandono do TARV e 22 pacientes na situação de *gap* por outros desfechos. ***Conclusão: conclui-se que houve aumento de 360,87% no *gap* de tratamento das pessoas vivendo com o HIV/Aids entre 2017 e 2018, e que os fatores e causas associados foram a recusa do tratamento, o abandono de TARV, óbito e desfechos diversos. Salienta-se que o estudo não mostrou significância quanto à condição clínica, situação conjugal, socioeconômica e abandono do tratamento, e que as lacunas enormes na cobertura do tratamento, estigma e discriminação continuam a prejudicar a efetividade das respostas. ***Descritores*:** Recusa ao Tratamento; HIV/Aids; Acompanhamento dos Cuidados de saúde; Serviços Ambulatoriais de Saúde; Pacientes que Abandonam o Tratamento; Monitoramento do Paciente.

RESUMEN

Objetivo: identificar los motivos asociados al retraso para el inicio del tratamiento de pacientes que viven con el VIH / SIDA. ***Método:*** se trata de un estudio cualitativo, descriptivo, transversal, realizado con 31 prontuarios de pacientes en la lista de gap de tratamiento, en el sistema SIMC del Ministerio de Salud, con análisis estadísticos realizados por el software SPSS. ***Resultados:*** se infiere que el gap de tratamiento del municipio, entre agosto a diciembre de 2017, fue del 21,7%, y, en 2018, fue del 78,3%; de estos, 21 pacientes se encontraban en situación de abandono del TARV y 22 pacientes en la situación de gap por otros resultados. ***Conclusión:*** se concluye que hubo un aumento del 360,87% en el gap de tratamiento de las personas que viven con el VIH / SIDA entre 2017 y 2018, y que los factores y causas asociados fueron el rechazo del tratamiento, el abandono de TARV, muerte y los distintos resultados. Se destaca que el estudio no mostró significancia en cuanto a la condición clínica, situación conyugal, socioeconómica y abandono del tratamiento, y que las lagunas enormes en la cobertura del tratamiento, estigma y discriminación continúan perjudicando la efectividad de las respuestas. ***Descriptores***: Negativa del Paciente al Tratamiento; VIH/SIDA; Continuidad de la Atención al Paciente; Atención Ambulatoria; Pacientes Desistentes del Tratamiento; Monitorización del Paciente.

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INTRODUCTION

Despite the improvements brought about by the treatment of Acquired Immune Deficiency Syndrome (AIDS), with antiretroviral therapy, this has resulted in the prolongation of the survival of people who acquired the disease, since it ceased to be considered fatal and became chronic[1], there are still many difficulties to be overcome. Challenges to services and health professionals are brought about by the patient's lack of adherence to treatment, [2] and adherence, despite being a dynamic and multifactorial process, since it includes physical, psychological, social, cultural and behavioral factors, requires a shared decision and co-responsibility between people living with HIV and the health team and its social network.[1-2] It is important to study adherence to the treatment of AIDS, because of the negative burden that the disease causes both the individual, his family and the community, which has very serious consequences and, moreover, the literature indicates that there is a relation between viral resistance, therapeutic failure and low adhesion.[3]

The difficulties present in this process are reported in several studies. These intercurrences are described as elements that interfere in adherence to therapy: side effects; financial conditions; quantitative of drugs and therapeutic complexity; impact on daily living activities; social support; emotional problems; use of drugs; organization of health services and the interaction with follow-up professionals.[4] Factors that interfere with the existence of side effects are considered: sickness and fear of death; the need to hide from the family, friends and work colleagues the diagnosis of HIV/ AIDS and, paradoxically, the sensation of these people, diagnosed with HIV, to be cured of feeling well, as this interferes with adhesion.[5]

In another study, three agents that facilitated adherence to antiretroviral treatment were identified: the family, the health professional, and the subject himself and, in relation to the subject itself, there is concern about the time to use the drug, since the inappropriate use of the medication, through constant delays, for example, can cause a mutation and consequent resistance of the virus to ART. It is known, with regard to the family, that this appears as a source of external mobilization of the individual, since family care facilitates the process of adherence to treatment. They also become important health professionals in adherence to treatment: they appear as subjects that welcome, stimulate and are interested in the routine of the person and, for the authors, the perception by the subject of the support offered by the family and the speech presented by health professionals, regarding the importance of the treatment, is internalized, assisting in the production of self-care.[2]

It is noted that the low immunity allows the appearance of opportunistic diseases, that would receive this name by taking advantage of the weakness of the organism and, with this, the more advanced stage of the disease, the AIDS, is reached. It is understood that those who reached this stage, not knowing or not following the treatment indicated by the doctors, will suffer from viral hepatitis, tuberculosis, pneumonia, toxoplasmosis and some cancers.[6]

It is observed that until the end of the 1980s, there was not much knowledge about the pathogenesis and history of HIV infection and this made it difficult to care for people living with HIV/AIDS (PLHA), limiting the treatment of opportunistic infections. Since the beginning of the epidemic, there have been 842,710 AIDS cases in Brazil from 1980 to June 2016, and from 2010 to 2014 there were an average of 40,600 new cases per year. It is known, in relation to mortality, that up to December 2016, there were 303,353 deaths, although a slight drop in the AIDS mortality rate in Brazil was observed, which increased from 5.9 per 100 thousand inhabitants in 2006 to 5,6 in 2015.[7] The emergence in 1987 with the advent of zidovudine (AZT) also led to therapeutic hope and research opening new perspectives for the treatment of AIDS.[8-9]

Early antiretroviral therapy is recommended in the current treatment protocol for HIV / Aids in order to provide a better quality of life for the patient and a way to prevent new infections through undetectable viral load. It was developed, by the Ministry of Health, to visualize and monitor the treatment gap, that is, people living with HIV / AIDS (PLHA) who have not yet started antiretroviral treatment, SIMC (Clinical People living with HIV / AIDS). The system crosses data between SISCEL (Laboratory Testing System) and SISCLOM (Drug Logistic Control System), linking the results of the laboratory tests with CD4 + / CD8 + and altered viral load with the ART withdrawal list.[10]

It was possible to identify, in the correlation, people who are not in treatment, but who could be. It is reported that all health services have access to the system, and

responsible staff must fill in the required fields with patient data and treatment, such as: reason for non-adherence (if the patient does not withdraw the medication), information on death, city change or non-initiation of treatment for medical recommendations, and if the person performs the treatment, it will not be part of the total treatment gap. Assistance services are therefore available to seek these people, offer ART and insert them into the treatment. It is demonstrated, when large proportions of people living with HIV are in treatment, a preventive effect within this community.[10-1]

Several factors are associated with the difficulty of adherence to the health service, which would be related to the virus itself, to the ARVs used, to the relationship problems with the health team, to the organization of the health system or to the psychosocial difficulties of the people who are living with HIV/AIDS. In the literature, several predictive factors for non-adherence to Highly Active Antiretroviral Therapy (HAART), which can be grouped in: factors related to the person being treated; the disease; treatment; health services and social support.[2-3,12]

OBJECTIVES

- To identify the reasons associated with the delay in starting treatment of patients living with HIV / AIDS.

METHOD

This is a cross-sectional study, with a descriptive design, using a qualitative and analytical approach, performed through the analysis of the physical records of the patients present in the list of reports generated through the SIMC, from August / 2017 to August / 2018 . The study was carried out at the Chronic Communicable Diseases Complex of São José do Rio Preto / SP, of the Municipal Health Department of the municipality, which has a total estimated population of 450,657 inhabitants.[13] The municipality was fully empowered by NOB / 96 and the Health Management Pact was signed in 2007.

The physical records of all adult individuals, regardless of gender, between the ages of 18 and 60, who were present in the system-generated report listing and who were diagnosed with HIV/AIDS and did not adhere to outpatient treatment, were analyzed. Inclusion criteria included patients who were followed up at the Complex of Chronic Communicable Diseases of the municipality, from the age of 18, who were HIV positive, who did not adhere to or abandoned the treatment, interrupting outpatient follow-up. Exclusion criteria were defined as those patients who were followed up at another health care unit and who were still receiving antiretroviral treatment. The patient's situation regarding the treatment was verified through the SIMC system, which performs the data crossing between the clinical condition of the patient and the non-withdrawal of the medications, generating a treatment gap listing that allows identification of the patient's status as a patient in refusal of treatment, patient abandoning ART and unauthorized consent, when the patient does not authorize the contact of the health service.

Two Microsoft Excel® worksheets, 2016, were used to collect data: one for the storage of patients' data in the treatment gap, from August / 2017 to August / 2018, and the second spreadsheet for data collection of the patients' charts selected for the analysis. The following variables are included in the latter: death, sex, age, enrollment (in days), schooling, marital status, municipality of residence, occupation, income, housing, means of transport, children, sexual practice, partnerships sexual partners, seropositive partnerships, condom use, if had more than three sexual partners during the life, drug use, STI histories and situation, being the time of enrollment (in days) the variable that quantifies the patient's time of knowledge about the diagnosis and its inclusion in the information system used by the Complex of Communicable Chronic Diseases.

Two statistical analysis functions were performed after data tabulation: descriptive and inferential. In the descriptive analysis, the profile of the sample studied was analyzed, considering the analyzed variables and their unfolding. The data were replicated in an absolute and relative way in this first part. In the inferential statistics, the analysis of independence and prediction among the variables proposed in the scope of work was treated. For this purpose, the Multiple Linear Regression test was used. The results of independence between the variables proposed were analyzed by means of analysis between P values (significance).

Statistical Package for Social Science (SPSS) software, version 23, was applied to the functionalities of the Microsost Excel® tool, version 2.016, for all analyzes. Methods of descriptive and inferential statistics were used, analyzing the probabilities of a population based on the sample data. The mean, median, mode, standard deviation, minimum value, maximum value, multiple

linear regression, Spearman's correlation, square R, significance, and standard error were used in some moments, given the need for a better understanding.

RESULTS

A report was generated, through the SIMC system, with information on the treatment gap of the municipality of São José do Rio Preto. Statistical analysis was excluded from data from patients attending a health service other than the Chronic Communicable Disease Complex of the Municipal Health Secretariat of São José do Rio Preto (SP).

Results were presented in Tables 1, 2, 3, 4, and 5, respectively.

Table 1. Distribution of the treatment gap report according to gender, age, month, year and treatment status of the patients. São José do Rio Preto (SP), Brazil, 2018.

	Abandoned ART		In treatment		Death		Other outcomes		Total	
	N	%	N	%	N	%	N	%	N	%
Sex										
Female	3	14.3	39	23.8	2	40.0	6	27.3	50	23.6
Male	18	85.7	125	76.2	3	60.0	16	72.7	162	76.4
Age group										
Up to 20 years	0	0.0	4	2.4	0	0.0	1	4.5	5	2.4
21 to 40 years	17	81.0	112	68.3	1	20.0	13	59.1	143	67.5
41 to 60 years	3	14.3	40	24.4	3	60.0	7	31.8	53	25.0
> 60 years	1	4.8	8	4.9	1	20.0	1	4.5	11	5.2
GAP										
January	1	4.8	16	9.8	0	0.0	0	0.0	17	8.0
February	0	0.0	12	7.3	0	0.0	0	0.0	12	5.7
March	0	0.0	4	2.4	0	0.0	0	0.0	4	1.9
April	19	90.5	47	28.7	5	100.0	19	86.4	90	42.5
May	0	0.0	6	3.7	0	0.0	0	0.0	6	2.8
June	1	4.8	27	16.5	0	0.0	2	9.1	30	14.2
July	0	0.0	5	3.0	0	0.0	1	4.5	6	2.8
August	0	0.0	13	7.9	0	0.0	0	0.0	13	6.1
September	0	0.0	17	10.4	0	0.0	0	0.0	17	8.0
October	0	0.0	7	4.3	0	0.0	0	0.0	7	3.3
November	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0
December	0	0.0	10	6.1	0	0.0	0	0.0	10	4.7
2017	0	0.0	46	28.0	0	0.0	0	0.0	46	21.7
2018	21	100.0	118	72.0	5	100.0	22	100.0	166	78.3
Total	**21**	**100.0**	**164**	**100.0**	**5**	**100.0**	**22**	**100.0**	**212**	**100.0**

It is inferred that, when analyzing the reasons for refusal or abandonment of ART, data were collected referring to a population of 75 patients present in the treatment gap recorded in the SIMC system and, from these, the study sample resulted in 31 patients who were in followed by the Chronic Communicable Disease Complex of the Municipal Health Department of São José do Rio Preto (SP), between February and May 2018. The sample was stratified according to the patients' situation, verified in the system report, classifying - those in: patients who refuse treatment; patients on ART abandonment and unauthorized consented approach, when the patient does not authorize contact, the descriptive statistics being performed after the separation of the data.

Table 2. Distribution of patients according to death and enrollment time. São José do Rio Preto (SP), Brazil, 2018.

	Patient Refuses Treatment		Patient in ART Abandonment		Unauthorized Consent Approach		Total	
	N	%	N	%	N	%	N	%
Death								
Death - No	7	100.0	21	91.3	1	100.0	29	93.5
Death – Yes	0	0.0	2	8.7	0	0.0	2	6.5
Time enrolled								
Up to 1000 days	1	14.3	6	26.1	0	0.0	7	22.6
1001 to 2000 days	5	71.4	9	39.1	1	100.0	15	48.4
2001 to 3000 days	0	0.0	5	21.7	0	0.0	5	16.1
> 3000 days	1	14.3	3	13.0	0	0.0	4	12.9
Total	**7**	**100.0**	**23**	**100.0**	**1**	**100.0**	**31**	**100.0**

Table 3. Distribution of patient characterization according to gender, age, schooling and marital status. São José do Rio Preto - SP 2018.

	Patient Refuses Treatment		Patient in ART Abandonment		Unauthorized Consent Approach		Total	
	N	%	N	%	N	%	N	%
Sex								
Female	2	28.6	4	17.4	0	0.0	6	19.4
Male	5	71.4	19	82.6	1	100.0	25	80.6
Age								
Up to 30 years	2	28.6	9	39.1	1	100.0	12	38.7
31 to 40 years	2	28.6	10	43.5	0	0.0	12	38.7
41 to 50 years	1	14.3	2	8.7	0	0.0	3	9.7
> 50 years	2	28.6	2	8.7	0	0.0	4	12.9
Education								
Incomp. Elemen. School	1	14.3	7	30.4	0	0.0	8	25.8
Comp. Highschool	3	42.9	6	26.1	0	0.0	9	29.0
Incomp. Highschool	0	0.0	5	21.7	0	0.0	5	16.1
Comp. Higher Educ.	1	14.3	3	13.0	0	0.0	4	12.9
Incomp. Higher Educ.	2	28.6	2	8.7	1	100.0	5	16.1
Marital status								
Single	5	71.4	18	78.3	1	100.0	24	77.4
Married	1	14.3	2	8.7	0	0.0	3	9.7
Others	1	14.3	3	13.0	0	0.0	4	12.9
Total	**7**	**100.0**	**23**	**100.0**	**1**	**100.0**	**31**	**100.0**

Table 4. Distribution of the characterization of patients according to the municipality of residence, occupation, income, housing, means of transport and children. São José do Rio Preto - SP 2018.

	Patient Refuses Treatment		Patient in ART Abandonment		Unauthorized Consent Approach		Total	
	N	%	N	%	N	%	N	%
Municipality of residence								
São José do Rio Preto	7	100.0	21	91.3	1	100.0	29	93.5
Others	0	0.0	2	8.7	0	0.0	2	6.5
Occupation								
Active	5	71.4	18	78.3	1	100.0	24	77.4
Inactive	2	28.6	5	21.7	0	0.0	7	22.6
Income								
Retired or Pensioner	0	0.0	3	13.0	0	0.0	3	9.7
Without income	3	42.9	8	34.8	1	100.0	12	38.7
Autonomous	1	14.3	3	13.0	0	0.0	4	12.9
Employed	3	42.9	9	39.1	0	0.0	12	38.7
Home								
Owned	1	14.3	7	30.4	1	100.0	9	29.0
Rented	5	71.4	8	34.8	0	0.0	13	41.9
Others	1	14.3	8	34.8	0	0.0	9	29.1
Means of transportation								
Bus	2	28.6	12	52.2	1	100.0	15	48.4
Car	2	28.6	4	17.4	0	0.0	6	19.4
Others	3	42.9	7	30.4	0	0.0	10	32.3
Children								
No	5	71.4	16	69.6	1	100.0	22	71.0
Yes	2	28.6	7	30.4	0	0.0	9	29.0
Total	**7**	**100.0**	**23**	**100.0**	**1**	**100.0**	**31**	**100.0**

Table 5. Distribution of patients according to sexual practice, sexual partnerships, seropositive partnerships, more than three sexual partners throughout life, condom use, history of STI and drug use. São José do Rio Preto (SP), 2018.

	Patient Refuses Treatment		Patient in ART Abandonment		Unauthorized Consent Approach		Total	
	N	%	N	%	N	%	N	%
Sexual Practice								
Relations with men	5	71.4	16	69.6	1	100.0	22	71.0
Relations with women	0	0.0	6	26.1	0	0.0	6	19.4
Relations with men/women	2	28.6	1	4.3	0	0.0	3	9.7
Sexual partner								
One	2	28.6	8	34.8	1	100.0	11	35.5
Multiple	2	28.6	8	34.8	0	0.0	10	32.3
Others	3	42.9	7	30.4	0	0.0	10	32.3
HIV positive partners								
Yes	2	28.6	5	21.7	0	0.0	7	22.6
No	0	0.0	2	8.7	0	0.0	2	6.5
Ignored	5	71.4	16	69.6	1	100.0	22	71.0
More than three sexual partners during life?								
Yes	5	71.4	21	91.3	1	100.0	27	87.1
No	2	28.6	2	8.7	0	0.0	4	12.9
Use of preservatives								
Always	1	14.3	3	13.0	0	0.0	4	12.9
Never	1	14.3	5	21.7	0	0.0	6	19.4
Sometimes	5	71.4	15	65.2	1	100.0	21	67.7
History of STIs								
Yes	4	57.1	9	39.1	1	100.0	14	45.2
No	3	42.9	14	60.9	0	0.0	17	54.8
Use of drugs								
Yes	6	85.7	16	69.6	1	100.0	23	74.2
No	1	14.3	7	30.4	0	0.0	8	25.8
Total	**7**	**100.0**	**23**	**100.0**	**1**	**100.0**	**31**	**100.0**

DISCUSSION

Nonadherence to antiretroviral treatment was seen as one of the greatest threats to the effectiveness of ART, to the spread of the virus and to the emergence of resistance in the collective sphere, because the new therapeutic regimens for seropositive people maintain them with high life expectancy, treating HIV / AIDS no longer as a fatal disease, but as a chronic disease. It adheres to the principle of autonomy, as the patient's agreement is required to follow the recommendations indicated, implying the proactive role of caring for one's own health. It is understood that the treatment process requires, from the individual, for the adhesion, a complex integration between the acceptance of the diagnosis, knowledge and coping skills, which are interfered with by other factors related to the social environment and to health care.[14]

It is understood in the literature that non-adherence occurs to some degree in both poor and rich countries, and the average rate of adherence is 50%. Some factors are considered relevant and associated to the reason for abandonment or refusal to treatment. It is described in studies that outpatient professionals working with HIV-infected persons know the risk factors for non-adherence to ART in their specific group of clients.[15]

In Brazil, according to the HIV / AIDS Epidemiological Bulletin of 2017, from 1980 to June 2017, 576,245 (65.3%) cases of AIDS in men and 306,444 (34.7%) in women were registered. The ratio of the sexes to the ratio of the number of HIV / AIDS cases in men and women, from 2009, to 22 in AIDS cases in men for every ten cases in women in 2016 is expressed. - the virus detection rates in men, in the last ten years, the growth trend; in 2006, the rate was 24.1 cases / 100 thousand inhabitants, which rose to 25.8 in 2016, representing an increase of 7.1%.[15] The prevalence of males (76.4%) among individuals in the treatment gap is shown by the results, as well as the predominance of patients in the age group of 21 to 40 years (67.5%), who presented the higher concentration of HIV / AIDS cases in Brazil. It was observed that there was a low but significant (sig.0.049) level correlation between age and susceptibility of people living with HIV and, according to research, the highest proportion of cases of the virus is in individuals aged 25 and 39 years.[11]

There were two deaths (6.5%) among patients who were on treatment abandonment, but it was not possible to associate the abandonment of ART with the cause of death. In these cases, however, it is known that the HIV / AIDS virus acts on the individual's immune system making him vulnerable and fragile. It can be seen that, similarly, the results did not show that the patient's time of knowledge about his diagnosis and the need for outpatient follow-up (enrollment time) are relevant to the individual's treatment situation, with a higher enrollment time to two years for most of the sample (48.39%).

It was verified that the degree of schooling of the sample did not allow a correlation with the patient's treatment situation, showing little difference between individuals with incomplete Elementary School (25.81%) and those who finished High School (29.03%). One can contribute, by the time of study of the individual, to explain the difficulty that many patients have to understand the importance of adherence to treatment.[17] It is also noted the prevalence of males in the non-adherence to treatment, represented by 80.65% of the sample. In some studies, there is a higher rate of non-adherence to ART for males, as is the frequency of female absences in clinical follow-up visits, showing that women are at high risk of non-adherence. adherence to treatment, which may be associated to the fact that they need to perform housework, organize the routine of the family and take care of the children, occurring the forgetting of a greater number of doses of the medication.[18] Other authors present the idea that, in general, adherence to treatment increases with age[15] and the results allow the visualization that the age group of 41 to 50 years and over 50 years is composed of individuals with lower percentage of treatment discontinuation.

The socioeconomic reality of the individual was pointed out as a low risk factor for non-adherence to treatment, and the sample had similar percentages of non-adherent individuals who reported having an employment relationship (employees, 38.71%) and those who have no income (38.71%). However, it was observed that the income variable ($p = 0.196$) was the one that reached the significant value of the dependence coefficient ($p < 0.05$), and could be associated with the treatment situation of the individual, and the type of occupation may also be a factor of direct association with adherence, generating a negative impact on client participation in its treatment. Housing should be evaluated when it is a situation of extreme poverty, since such a condition may impose difficulties in accessing treatment, [15,17,19] however, only 19.35% of the sample stated that they lived in a place provided by relatives or acquaintances and 9.68%, in the workplace or in the street, and the rest of the sample residing in a rented house, owned and paid for and not removed, which did not make possible the correlation between the non-adherence to ART and the individual's living style. The means of transport is configured as a variable that also determines the socioeconomic status of the patients analyzed, however, there is no correlation with the treatment situation, since only 9.68% of the sample stated that they did not have access to any type of means of transport except on foot, while the others reported having access to the collective transportation of the municipality, car, among other means.

It was identified that, as far as paternity is concerned, the fact that the individual has children or not can not be related to the treatment situation, and no research was found that made this comparison, being possible to observe, in the results, that 70.97% of the sample had no children. 28.57% of the individuals, who confirmed that they had a child, refused treatment, and of these, 30.43% were in abandonment of ART. It was verified that, from the sexual practices, the variable with significant value in relation to the coefficient of dependence ($p < 0.05$) was the amount of sexual partnerships during the life (Have you had more than three sexual partners during the lifetime? $p = 0.201$). It is inferred that the majority of the sample, 87.10% (27 patients), confirmed to have maintained a relationship with more than three partners during the life and, concurrently, 70.97% (22 patients) confirm to ignore the possibility of their partners the seropositive diagnosis, a cause of concern and that has a direct relation with the spread of the virus. The predominance of males in the detection rates of the virus in relation to sexual practices can be related to the fact that the majority of individuals have sex with men (70.97%).[16] The results show that only 9.68% of the sample reported having relations with men and women, and 19.35% with only women.

It was observed that, in terms of sexual practices, one patient (3.23%) reported having multiple and regular intercourse and three patients (9.68%) maintained multiple and occasional relationships, ie some individuals confirmed having had or maintained relations with more than one person on a regular basis,

stating that they also maintained possible concomitant. Twenty-one patients (67.74%) reported using condoms sporadically, an alarming situation with regard to the spread of the virus, since Latin America represents 45% (33-51%) of people living with HIV And Western Europe and North America account for 51% (39-60%) of the population living with HIV/ AIDS, with the lowest coverage being in the Middle East and North only 11% (8-16%).[20]

It was observed that eight out of 31 patients in the sample reported not using any drug, including alcohol, and studies indicate that chemical dependence may be one of the risk factors for refusal of ART, more frequently, proving situations treatment for those who start it. It is pointed out in studies the ingestion of alcohol as a factor that predisposes to nonadherence to treatment, starting from the common sense among the population that drinks and medicines can not be mixed, and this contributes so that even people with good adhesion stop to take the drugs to consume alcohol, even if socially.[21] It should be noted that the fact that the patient has a history of some sexually transmitted infection can not be related to his / her treatment situation, observing the proximity of values, since, among 17 individuals (54.84%) of the sample who do not have a history of STI, 14 (45.16%) have already been sexually infected. The fact is associated with the perception of control over one's own health, and some studies seek to verify if there is a relationship between the perception of control over health and adherence to the treatment of some chronic problems such as hypertension and diabetes. It is the expectation of control as an element that interferes with the coping of situations and, consequently, the patient's adaptive capacity, and a study carried out in Brazil among HIV positive clients of a bed-day hospital in HAART treatment did not show relationship between control locus and non-adhesion.[22-3]

CONCLUSION

It was verified that there was a 360.87% increase in the treatment gap of people living with HIV / AIDS, between 2017 and 2018, in the city of São José do Rio Preto / SP. It is known that the factors and causes associated with the treatment gap were refusal of treatment, abandonment of ART, deaths and various outcomes. It is revealed that the study did not show significance regarding the clinical condition, marital status, socioeconomic status and abandonment of treatment. It is verified that the theoretical implications of the results and the contribution of the study to the advancement of scientific knowledge are strategies for reducing the gap generated by duplicity, identifying the real quantitative gap of treatment, as well as knowing and identifying users and causes of the treatment gap, developing strategies to reduce the gap and providing adequate treatment and follow-up for the population.

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