



STIGMA AND RAPID TESTING IN PRIMARY CARE: USERS' AND PROFESSIONALS' PERCEPTION

Estigma e teste rápido na atenção básica: percepção de usuários e profissionais

Estigma y prueba rápida de la atención básica: percepción de usuarios y profesionales

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ABSTRACT

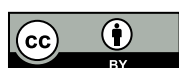
Objective: To analyze how stigma and discrimination related to Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome (HIV/AIDS) are presented in the everyday lives of users and professionals in the context of the implantation of rapid testing for HIV and other Sexually Transmitted Infections (STI) in Primary Health Care. **Methods:** Qualitative, exploratory study, performed in 2015 in 15 health care units of Porto Alegre, Brazil. Participants were 64 people, 34 users and 30 health professionals of different fields. Data was collected using semi-structured interview and organized based on the thematic analysis of the participants' statements. **Results:** The stigma associated with HIV/AIDS is present in the different speeches of the interviewees. Participants showed similarities in indicating who should take the rapid HIV test, citing drug users, adolescents and women. The respondents perceive stigma and discrimination in the community and health services, and the professionals say that there is prejudice on the part of staff members and even the service users, not becoming involved in this process. Considering Aids as any disease is a way of neutralizing the identification of stigma, which does not recognize the historical specificities of HIV and the singularities of the people affected. **Conclusion:** The challenge faced by Primary Health Care is to recognize the concepts that underpin the identification of individuals vulnerable to HIV/AIDS, so as to avoid reproducing stigma that hamper health promotion.

Descriptors: Stigma; Primary Health Care; Aids Serodiagnosis.

RESUMO

Objetivo: Analisar como o estigma e a discriminação estão presentes no cotidiano de usuários e profissionais no contexto de implementação do teste rápido para HIV/AIDS na Atenção Básica. **Métodos:** Estudo qualitativo, de caráter exploratório, realizado em 2015, em 15 unidades de saúde de Porto Alegre, Brasil. Participaram 64 pessoas, sendo 34 usuários e 30 profissionais de saúde com diferentes formações. Os dados foram coletados através de entrevistas semiestruturadas e organizados a partir da análise temática das falas dos participantes. **Resultados:** O estigma associado ao HIV/AIDS se faz presente nas diferentes falas dos entrevistados. Os participantes apresentaram semelhanças na indicação de quem deveria realizar o teste rápido de HIV/AIDS, citando usuários de drogas, adolescentes e mulheres. Os entrevistados referem estigma e discriminação na comunidade e nos serviços de saúde, sendo que os profissionais afirmam que existe preconceito por parte de membros da equipe e dos próprios usuários do serviço, sem implicarem-se nesse processo. Considerar a AIDS como uma doença qualquer é uma forma de neutralizar a identificação do estigma, não reconhecendo as especificidades históricas do HIV e as singularidades das pessoas afetadas. **Conclusão:** O desafio da Atenção Básica é reconhecer quais são os conceitos que embasam a identificação de pessoas vulneráveis ao HIV/AIDS, para que não se reproduzam estigmas que entravam a promoção de saúde.

Descritores: Estigma Social; Atenção Primária à Saúde; Sorodiagnóstico da AIDS.



RESUMEN

Objetivo: Analizar como el estigma y la discriminación están presentes en el cotidiano de los usuarios y profesionales en el contexto de la implementación de la prueba rápida del VIH/SIDA en la Atención Básica. **Métodos:** Estudio cualitativo de carácter exploratorio realizado en 2015 en 15 unidades de salud de Porto Alegre, Brasil. Participaron 64 personas y de esas, 34 usuarios y 30 profesionales sanitarios con distintas formaciones. Los datos fueron recogidos de las entrevistas semiestructuradas y organizados a partir del análisis temático de las hablas de los participantes. **Resultados:** El estigma asociado al VIH/SIDA está presente en las distintas hablas de los entrevistados. Los participantes presentaron similitudes para la indicación de quien debería realizar la prueba rápida del VIH/SIDA citando los usuarios de drogas, los adolescentes y las mujeres. Los entrevistados refieren el estigma y la discriminación de la comunidad y los servicios de salud y los profesionales afirman que hay prejuicio de parte de los miembros del equipo y de los propios usuarios del servicio sin implicarse en ese proceso. Considerar la SIDA como una enfermedad cualquiera es una manera de neutralizar la identificación del estigma sin reconocer las especificidades históricas del VIH y las singularidades de las personas afectadas. **Conclusión:** El desafío de la Atención Básica es reconocer cuales son los conceptos que basan la identificación de las personas vulnerables al VIH/SIDA para que no se reproduzcan estigmas que entran la promoción de la salud.

Descriptor: Estigma Social; Atención Primaria de Salud; Sorodiagnóstico del SIDA.

INTRODUCTION

The Human Immunodeficiency Virus/Acquired Immune Deficiency Syndrome (HIV/AIDS) epidemic rates remain a global concern. Currently, 36.7 million people are living with HIV worldwide⁽¹⁾. The AIDS incidence rate in 2016 is 19.1, measured for every one hundred thousand inhabitants, in Brazil; specifically, it reaches 34.7 in Rio Grande do Sul and 74 in Porto Alegre⁽²⁾.

The stigma associated with HIV/AIDS is present in the daily lives of people living with HIV, and affects the access to health, job opportunities and community integration⁽¹⁾. Stigma is defined as the restriction of people's image to their undesired characteristics in a given context, which points to some flaw, defect or disadvantage⁽³⁾. Stigma is defined as a social process linked to the relations of power and domination that derive in stereotypes, categorizations and social contempt, so that, in a discriminatory way, some groups are valued, while others are devalued^(4,5).

AIDS-related discrimination emanates from the stigma associated with the history of the disease. HIV infection remains associated with moral judgments regarding sex and sexuality, as it is predominantly characterized by sexual transmission⁽¹⁾. Research on HIV/AIDS-related stigma tends to be restricted to describing experiences and to individual perceptions. Thus, the studies do not consider stigma a social process interconnected with other axes, such as gender, poverty, sexuality and race/ethnicity, which produce inequalities⁽⁶⁾.

In general, stigma and discrimination are conceptualized as phenomena produced by dynamics of power, domination and social coercion, which reinforce the exclusion of certain people, subjecting them to lower-quality health conditions^(4,7). Studies discuss the relation between homophobia and the production of stigma associated with HIV and AIDS, especially in contexts where some characteristics are common in relation to sexual diversity, such as unstable material conditions of life, traditional norms of gender and situations of violence⁽⁸⁻¹⁰⁾.

It should be noted that, in the context of collective health, since the 2000s, the Ministry of Health has developed guidelines for HIV/AIDS care in Primary Health Care (PHC), such as the insertion of counseling and the incentive for the HIV diagnostic offer⁽¹¹⁾. In 2012, the decentralization of rapid HIV testing was first implemented within the PHC context⁽¹²⁾.

Rapid testing is a technology that addresses the needs related to HIV/AIDS prevention and health promotion⁽¹³⁾. The National Policy on Health Promotion (*Política Nacional de Promoção da Saúde - PNPS*) has as one of its purposes the implementation of actions directed at the PHC. This policy allows the visibility of the factors that put the health of the population at risk, bearing in mind the population contexts, aiming at the reduction of vulnerabilities⁽¹⁴⁾. In this sense, the rapid test fits into this perspective, since it provides, in addition to the diagnostic offer, counseling, which consists in information exchange, emotional support and risk management⁽¹²⁾.

It is discussed in the literature the degree to which the policy of territorialization of users of the Unified Health System (SUS) can work as a facilitating element for the access to health, given the stigma and discrimination that permeate the care for people living with HIV/AIDS⁽¹⁵⁾. One study identified that PHC users were worried about the confidentiality of HIV/AIDS diagnosis, given the social prejudice, fearing that they might be perceived in the community, which was not the case in other care situations⁽¹⁶⁾.

The decentralization of the rapid HIV testing and other Sexually Transmitted Infections (STIs) towards the PHC brings about a significant shift in care, previously performed primarily at specialized Counseling and Testing Centers (CTCs) and currently available at referral units near the users' residence. The literature points out that the stigmatizing beliefs of professionals can become a barrier to the access to health^(17,18).

In this sense, this study conjectures: how does the policy of decentralization of the HIV/AIDS rapid testing in PHC impact the relationship between users and professionals?

Thus, the objective of this study is to analyze how stigma and discrimination are present in the daily lives of users and professionals in the context of the implementation of rapid testing for HIV/AIDS in PHC.

METHODS

This is a qualitative, exploratory and descriptive study⁽¹⁹⁾, carried out in 2015 in 15 Primary Health Care (PHC) units in Porto Alegre, Rio Grande do Sul, Brazil, comprising eight Primary Health Care (PHC) units and seven Family Health Strategy (FHS) units. The health units were chosen by lot⁽¹⁹⁾ among the eight services that most frequently performed the rapid test and the eight services that performed the least, and one health unit did not accept to participate in the research. These data were obtained in partnership with the HIV Coordination of the Municipal Health Secretariat, based on an internal survey not publicly available.

Sixty-four people were selected using convenience sampling⁽¹⁹⁾, resulting in 34 users and 30 PHC professionals with different backgrounds: nineteen nurses, three nursing technicians, two community health workers, two gynecologists, one family doctor, two dental surgeons, and one nutritionist. The coordinators of the services were contacted via telephone for research presentation and visit scheduling. The users and professionals were invited to take part in the study at their referral units. Only those professionals who had been trained to perform the rapid test and the users over the age of 18 participated. The sample number was determined in the research design, considering the participation of, at least, two professionals and two users per health care unit. Those participants who did not meet the aforementioned recommendations were not included.

Semi-structured interviews were used for data collection, comprising questions about the implementation of the rapid testing in PHC, starting from the analysis of three triggering questions: 1) "In your opinion, who should take the rapid HIV test?"; 2) "Do you perceive the existence of stigma/discrimination in the health service and/or in the community?"; and 3) For professionals: "Would you get tested in your health unit?"; and, for users: "Would you undergo the procedure for HIV detection at your health unit?"

The interviews lasted approximately 30 minutes and were recorded and transcribed verbatim. For data analysis, the thematic analysis was used, according to the following steps: detailed transcription of the interviews; initial codification of the most relevant themes from exploring the material; choice and definition of related topics; re-reading and recoding of the interviews; organization and interpretation of data; writing of the data analysis interconnecting analytical narrative and illustrative extracts⁽²⁰⁾. For systematization of the interviewees' reports, the following thematic axes were used: Indication of who should be tested: the stigma permeating different populations; Testing and treatment in Primary Health Care: factors interfering with the decision; and Identification of stigma and discrimination in the service and the community.

This study is part of a larger study titled "Evaluation of the process of implementation of the policy of decentralization of rapid testing for HIV in the PHC from the perception of matrix supporters, professionals and users." The ethical issues were assured, and the research was submitted to and approved by the Research Ethics Committees of the Pontifical Catholic University of Rio Grande do Sul and the Municipal Health Secretariat of Porto Alegre (Approval No. 981.527). All participants signed the Informed Consent Term. In order to protect the participants' identity, the speeches were identified using "P" for professionals and "U" for users, not mentioning managements and services of origin.

RESULTS AND DISCUSSION

In this space the thematic axes that emerged after analysis of the speeches are presented. An interpretative synthesis was elaborated, in which the participants' speeches are engaged in a dialog with the scenario of HIV/AIDS stigma and the context of the rapid testing in PHC. In the sequence, the three thematic axes that were built are presented: Indication of who should be tested: the stigma permeating different populations; Testing and treatment in primary health care: factors interfering with the decision; and Identification of stigma and discrimination in service and community.

Indication of who should be tested: the stigma permeating different populations

In this axis, it is indicated who should take the rapid test. When questioned, the respondents resorted to generalist responses, more often indicating that all people are infected with the virus. The participants indicated that there was no longer a risk group and that having sexual relations would already be indicative of exposure to the virus, as can be observed:

"I find it hard to think of a most vulnerable group. People used to say that the "gays" were the ones, but that is long gone. I don't think there is a most vulnerable group. I think everyone is." (U8)

It is noticed that speech articulates the idea that all people need to be careful about the risk of acquiring HIV. This may be associated with the mobilization of civil society and public management in the face of the HIV/AIDS epidemic, in seeking strategies to reduce the vulnerability of the populations affected at the beginning of the epidemic⁽²¹⁾. Based on HIV/AIDS coping policies in Brazil, the focus on specific populations has been gradually removed, recognizing that the risk of infection is linked to sexual practices without the use of condoms.

Generalized responses of the participants may be an automatic way of not characterizing a stigmatizing viewpoint. On the other hand, it is noted that the interviewees identify different groups as priorities to getting tested, such as drug users, women and adolescents/youth. Among these, the points associated with the vulnerability of drug users, which concern the situation of poverty, the lack of demand for care and the sharing of syringes, stand out:

"Here, in the neighborhood, there are many drug addicts, people with poor schooling, who become ignorant." (U19)

"I would like to perform the test with the people there that we call 'Carandiru', which is an area in the neighborhood, that is, the people with drug addiction." (P26)

It is perceived that the participants identify the intersection between stigma and poverty. Stigma is directly related to the axes of social inequality that operate in social interactions⁽²²⁾ entre prostitutas, mulheres que abortam e mulheres vivendo com o vírus da imunodeficiência humana (HIV). Thus, social inequalities strengthen the production of stigma. Such inequalities extend to different populations, such as adolescents, women, homosexuals and the elderly. Generational discrimination, sexism, racism and homophobia are present, whether veiled or explicit, in Brazilian society⁽²³⁾.

With respect to the adolescents, the professionals listed as reasons for the increase in the HIV incidence in this group, the fact that they did not use a condom. According to the users, young people should be tested for being more susceptible to drug use and unplanned pregnancy. The literature points out that the shortfall in information associated with sociocultural issues and the precarious HIV-related preventive orientation have influenced unprotected sexual practice, increasing the HIV rates⁽²⁴⁾.

Women were identified as more vulnerable to HIV in different phases and situations of life. This can be observed in the following excerpts:

"The outfit, isn't it? To school, we have been a few times, and you see (sic) how girls behave: all hanging out with a boyfriend, underage... And even pregnant women here, who became mothers at thirteen. I believe they are the most susceptible ones." (P5)

"There are a lot of pregnant teenagers, and pregnancy means they did not use the condom, so it can pass (virus). This should be more focused on the teenager's head." (U21)

"Married women, this is the most vulnerable public, who think they are protected but are not." (P1)

It is observed that, for the participants, being a woman indicates greater susceptibility to the risk of infection, showing an important permeation of gender-related prejudice. In contrast, there is a tendency to reduce the incidence of infection among women, both in Brazil⁽²⁾ and in Rio Grande do Sul⁽²⁵⁾.

In the current research, one can perceive through the interviewees' statements how female sexuality is permeated by the perception of risk that involves the various manifestations and moments of life. As it appears both in users' and professionals' speech, this aspect reflects how stigmatizing and culturally present these conceptions are. Thus, the development of the body, gestation and sexual life of women has always been a reason to care and control.

One study evaluated that the social representations concerning the exposure of women to HIV/AIDS, when negatively associated, that is, when they are blamed for the infection, compromise the quality of health care and

the bond between health professionals and users⁽²⁶⁾. Other research indicates that health services are not always successful in providing means for women to exercise their sexualities with low risks. This leads, for example, to the disconnection between the offer of contraception and HIV prevention, and failures in pre-and post-testing counseling, mainly with respect to the non-approach to sexual practices and risk management⁽²⁷⁾.

The interviewees did not identify homosexuals as a target audience for testing. The professionals observe that there was a change in the profile of those infected by HIV/AIDS, considering a greater generalization of the epidemic:

“If you are a teenager, you don’t even know about 1980, about who were the people who got sick. I remember that story: ‘If you are not a homosexual, you will not get it.’ So what happened? What is happening now: elderly, adolescent, stable relationships. I think HIV prejudice is what hampers the most.” (P20)

It can be seen that the cultural issue of the direct association between the homosexual population and HIV can be a risk factor that hinders the self-perception of vulnerability by other populations. Moreover, among health professionals, there is a breakdown of the epidemic paradigm as something linked to the homosexual community. This may be a positive reflection of policies aimed at HIV prevention, which have deconstructed this stigmatizing concept over the past 30 years⁽²⁸⁾.

The professionals of the present study also pointed out the elderly as another target audience, since they present an active sexual life and do not have the habit of using a condom. It should be pointed out that users do not mention the risk of the elderly contracting the virus, corroborating what is pointed out in the literature: in the social conception, the elderly’s sexuality is denied and treated with prejudice^(29,30).

The studies indicate that the elderly’s sexual life is invisible, and health professionals share this belief^(31,32). However, there has been a 20% increase in the HIV detection rate in the elderly population (over 60 years) between 2006 and 2015⁽²⁵⁾. Thus, the view of this professional (P20) is sensitive to this condition of invisibility.

It is important to emphasize that the global goals of the World Health Organization (WHO), through the Joint United Nations Programme on HIV/AIDS (UNAIDS), aim at controlling the epidemic by 2020, with the 90-90-90 goal, that is, 90% of people with HIV being aware of the diagnosis, 90% of those diagnosed on treatment, and 90% of those on treatment with an undetectable viral load. These goals aim at the promotion of health and consider all populations and territories, without discrimination⁽¹⁾.

In this sense, it is noticed that the answers of the professionals in the current study are in line with this propositional diagnostic vision. However, in order to make health promotion viable, it is necessary to perceive the singularities of exposure according to the specific attributes of HIV infection of different populations, in order to promote the risk management of people facing their particular vulnerabilities⁽¹⁴⁾.

Testing and treatment in Primary Health Care: factors interfering with the decision

In the axis regarding the testing and treatment in PHC, the users show availability to carry out the HIV/AIDS treatment in the unit of their territory. Among the reasons presented are the ease of access and the proximity of the unit to their residences. Furthermore, some users have reported the bond established with the health professionals as a justification:

“I would, I’m more accustomed to this unit, I don’t like going to a hospital. I feel fine here.” (U1)

“I think I would undergo treatment here. The other units are very far (...). Here in this unit, one is acquainted with everybody. You know whom you can talk to more openly, it’s harder to go to a strange place, where we’re not acquainted with anyone.” (U21)

The examples of these statements present the decentralization of HIV care and treatment as a positive initiative, facilitating the strengthening of bonds, considering that, in PHC, there is a greater proximity between the service and the community^(33,34). Thus, the bond established between users and professionals seems to act as a protective element against the stigma and discrimination, promoting greater freedom and openness to dialogue between the user and the professional.

On the other hand, other users shared their opinions, indicating misgivings about the team secrecy, discrimination, apprehension about being identified in the community and lack of confidence in the treatment offered:

“Because of the discrimination, maybe I would not do it. If I were (HIV) infected, I would certainly not, because the discrimination is brutal.” (U9)

"No, because I do not trust (the health care unit staff) a lot, a hospital is something else." (U13)

It is perceived that opinions are divided according to the bond established with the service. On the one hand, the users who feel embraced by the team prioritize the service in the unit of their territory. On the other hand, those who do not trust the team prefer to be cared for where they can manage to remain anonymous, due to fear of discrimination. The literature indicates that the preference for health care at the primary level is directly related to the implantation of the user embracement in the services⁽³⁵⁾.

Similarly to the users' responses, the professionals who were interviewed also indicated that the bond with the team would be a facilitator for testing in the PHC units:

"I would do it, unconcernedly. I would feel even safer doing it in my area, with professionals that I have a certain bond with, than doing it in another area, with a stranger." (P25)

It is also emphasized that the professionals affirmed that they would get tested in their unit of work or in the referral unit, for being certain that the current diagnosis is negative. Thus, this may have influenced the safety of responses about testing, since the anxiety and hesitation to testing are related to the self-perception of exposure to the risk of infection:

"I would take it, because I know I'm (HIV) negative. If I were to suspect that I am positive, I don't know. It's a difficult thing, asking a colleague to perform a rapid test on me, because I suspect that I can be positive for some reason and, if positive, I don't know how I would elaborate it." (P16)

Other professionals, however, showed a tendency not to take the rapid test in PHC. They cited as justification the stigma and discrimination, showing fear of rejection by the pairs in relation to the possibility of a positive diagnosis:

"This is very complicated. While you are the one providing care, it's one thing, but when you're going to be cared for, it becomes a different thing. Sometimes, the person gets very afraid, does not want to be exposed in the work environment, but, as a health professional, I see no problem in taking it. I think that was the hardest question, putting my self in the user's shoes." (P13)

It is noted that the response of the professionals in the present research regarding the availability to testing and treatment is related to the social roles developed. As professionals, they do not identify reasons for not taking the test, given the principles of the policies for preventing the progression of the epidemic. In the position of users, affective and stigma-related issues surface, highlighting the fear of exposure before the reaction of colleagues and community. Therefore, it is evidenced that the rigidity of the social roles played hinders the bonding between professionals and users. Thus, the promotion of empathy stands out as a fundamental element in the process of reducing HIV/AIDS stigma⁽³⁶⁾, this being a key factor for approximation and establishment of trust between professionals and users, which provides a favorable scenario for health promotion.

Identification of stigma and discrimination in the service and the community

In this axis it is presented how the interviewees perceive the stigma and discrimination in the service and the community. Among the professionals, a few mentioned the presence of HIV-related stigma and discrimination, with most of the events described being related to the user's prejudice. They report that users are afraid to get tested and be recognized, but also express difficulty in living with people with HIV. From their perspective, users use protective strategies that are not linked to HIV transmission, such as avoiding hugs, not sharing home appliances and circulation settings:

"I have a case where the family ended up isolating their brother, built him a separate house, because he had a niece who was pregnant... so there is still a very strong discrimination." (P12)

It is noteworthy that the professionals identify prejudice on the part of other team members. Respondents report that, although the professionals hold the technical knowledge of ways of transmitting HIV, some fear becoming infected by contact with users. This highlights that, despite government campaigns for clarification of HIV/AIDS, knowledge is not enough to transform behaviors in relation to people with HIV and to prevention practices⁽³⁷⁾.

Similarly, when asked about the existence of stigma and discrimination, a few users also indicated the presence of such elements in the health service and in the community. One user reports that:

“In our own service there were people who kept looking and pulling a face, discriminating, you know.” (U17)

Some professionals recognize the existence of situations in which the team seems to naturalize prejudiced conceptions regarding people’s responsibility for the HIV infection:

“Not so much as regards the staff, but that also exists. Something like ‘look there, that dude whatshisname, always getting up to and then, now you see what’s happened? Now it’s no use complaining.’ Of course, people won’t ever say that to the patient, but in hallway conversations one can still hear that.” (P10)

This statement shows that the very narrative about transmission and illness teaches and reproduces chains of understanding based on the consequences of irresponsibility, indiscipline and excesses attributed to the other who is regarded as reckless. This process of trying to identify who is to blame for the HIV-positive diagnosis seems to contribute to the maintenance of stigma.

It is observed that the organization of the work in the primary health care units can be a facilitator for dissemination of confidential information, leading to ethical consequences related to the users’ privacy, value and autonomy. With this, the communication between the team members about the service and the users’ living situations can trigger the consolidation of discriminatory practices. On the other hand, the professionals report that they treat HIV with the same attention as other service demands:

“At the health care facilities, for us, an HIV patient is like if he were a patient with diabetes, we treat him the same way. In terms of prejudice, I see it that way. There are so many that they are already part of the quotidian, for us they are one more.” (P7)

In this sense, people with HIV are not given visibility, as the disease is perceived like any other, which reflects in the abstention from understanding and attending to the specificities of each person. By homogenizing the singularities, one tends to automate care, disregarding the need to dialogue about sexual practices and individual exposure risks. Moreover, such mechanization can serve as protection against the practitioner’s confrontation with their personal beliefs, masking stigmatizing conceptions.

The issue of AIDS is linked to the need to talk about sex, since this is a health condition that involves biomedical, social, political and cultural aspects. The agenda, in a decentralized approach, when merely focused on testing and medicalization, may overlook important intervention factors, which are empathy and the importance of affection in building relationships within and between the institutions for coping with and deconstructing stigma⁽³⁸⁾.

The literature points out that experiencing events of prejudice is not something restricted to specific spaces, as its institutionalization is present in different spaces and affects the health-disease process⁽²³⁾. Therefore, the stigma associated with stereotypes contributes to health conditions, as well as jeopardizing the exercise of citizenship and the right to health^(17,18).

In this sense, a user reports an experience in the service in which the PHC professional uses a stigmatized evaluation to refer to the degree of risk exposure in a given situation:

“I had relations with some girl from a party, and I didn’t even know who she was. She (the health professional) asked me how she looked, if she seemed to be a drug addict, something like that. I said no. She said the odds that I had contracted HIV were not so high.” (U14)

By resorting to a stereotyped profile of risk, the professional loses the opportunity to explore different situations of sexual practices in which the user could reflect and evaluate the factors involved in their exposure to the infection. Furthermore, this would enable protective conducts so as to stimulate the user’ autonomy.

Thus, even though practitioners affirm that there is little stigma in services on the part of the team, the fact that they use prejudiced conceptions can maintain stigmas that result in discriminatory relationships. Not encouraging the user to narrate their practices and present their doubts during the consultation seals the opportunity to reflect on preventive and health promotion tools.

Knowledge of and coping with HIV/AIDS must be developed in all social settings, the health services included, in an open way and free of moral judgments. Thus, continuing education can serve as an instrument to improve counseling on the rapid test in PHC, in a way that fosters the creation of self-care resources by the users, stimulating their autonomy in the management of their quality of life⁽³⁹⁾.

Managers, health professionals and other social leaders must assimilate that prevention is a human right and that it concerns everyone, regardless of their identification, agreement or not with their beliefs and with their sexual behaviors⁽⁴⁰⁾. Therefore, taking advantage of the expertise developed in the CTCs, for example, can be a form of intervention based on sharing their best practices within the PHC, by means of matrix support with participation of managers and professionals.

Moreover, one study identified that the rapid test and counseling were not being performed at the PHC level on the basis of spontaneous demand, and the units were resorting to scheduling⁽¹³⁾. Thus, the service on spontaneous demand is suggested, in the sense of embracing the user at the moment of anguish and courage when they seek testing. The waiting room can also be used as a space for guidance on sexuality and prevention of Sexually Transmitted Infections (STIs).

The professionals participating in this study, despite having done a course in HIV/AIDS testing, still show discrimination and prejudice when faced with the research questions. Therefore, it is also suggested that they take courses that can address their sexuality, so that they be able to assist in the questions about the sexuality of their clientele. It is also worth noting that the health professionals' awareness of the problems faced by the clientele with regard to HIV/AIDS is fundamental for promoting health to these individuals, providing opportunity for active listening, availability of supplies for protection against virus transmission, and information on healthy sexual practices, guaranteeing the satisfactory experience of their sexual health⁽⁴¹⁾.

Actions in this direction have the impact of opening up to dialogue, increasing the search for service, and consolidating prevention strategies, with a view to controlling the epidemic. For evaluation of the results of this intervention, it is possible to implement a pilot study with two health care units in order to monitor the development of these practices. Subsequently, conducting a comparative study is a way to verify the presence of stigma between the services in which the interventions were applied and those where they were not.

As a limitation of the study, it is worth mentioning that all the interviewees considered themselves to have an HIV-negative diagnosis, which may have influenced the responses. Because of the number of participants and services, the data cannot be generalized, but the results reflect the complexity of HIV/AIDS-related stigma within the PHC context.

FINAL CONSIDERATIONS

From the proposed objective, it is understood that the stigma associated with HIV is present in the different speeches of the interviewees. In general, professionals and users perceive stigma and discrimination in the community and in the health services, without a critical implication about their participation in this process.

Given the decentralization of the rapid HIV testing and other Sexually Transmitted Infections (STIs), the challenge posed to PHC is not to stimulate stigma. It is necessary to recognize that AIDS has its sociohistorical specificities that have unfolded along the formation of stigmas and discriminatory relations. Thus, it becomes relevant to understand the concepts that support the identification of each population as vulnerable to HIV/AIDS, so that the health services produce inclusive actions of health promotion.

ACKNOWLEDGMENTS AND CONFLICTS OF INTEREST

Thanks to the Ministry of Science, Technology and Innovation, and to the Research Support Foundation of the State of Rio Grande do Sul.

The manuscript bears no relations that could imply potential conflicts of interest.

CONTRIBUTIONS

In the present study, all authors participated equally in the research design, data analysis, structuring of results and writing of the manuscript.

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