

Counselling through the perspective of professionals of primary health care: challenges of decentralization of rapid test for HIV/Aids

Aconselhamento na perspectiva de profissionais da atenção básica: desafios na descentralização do teste rápido HIV/Aids

Asesoramiento en la perspectiva de profesionales de la atención primaria de salud: desafíos en la descentralización de la prueba rápida VIH / SIDA

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Abstract: This articles aims to investigate and analyze how rapid test and counselling for HIV were developed and assessed in decentralization process to primary care services. It is a qualitative and exploratory study, which was performed in 15 health services of Porto Alegre/Brasil, through semi-structured interviews with 22 professionals. Data were conducted to thematic analysis and discussed from theoretical perspective of “living work” in health by Merhy. Results were organized in two thematic axes: (1) Decentralization of testing in Primary Health Care; and (2) Counselling – topics and challenges. Results indicate: the activity is not presented transversally in the team, centralized in the nurses; greater domain in the execution of the test (hard technology) and informative approach (light-hard technology); insecurity regarding risk management and emotional support (light technologies), especially facing the positive diagnosis. One of the main challenges for the effectiveness of counseling is the appropriateness of the approach according to user’s necessity.

Keywords: counselling, HIV, serologic tests, primary health care, decentralization

Resumo: O estudo objetiva conhecer e analisar como o aconselhamento em HIV/Aids vem sendo desenvolvido na descentralização do teste rápido de HIV e outras Infecções Sexualmente Transmissíveis (IST) para a atenção básica. Trata-se de estudo qualitativo exploratório, realizado em 15 unidades de saúde de Porto Alegre/Brasil, através de entrevistas com 22 profissionais. Os dados foram submetidos à análise temática e discutidos sob a perspectiva do trabalho vivo em saúde de Merhy. Organizou-se dois eixos temáticos: (1) Descentralização da testagem na atenção básica; (2) Aconselhamento – elementos e desafios. Os resultados apontados foram: a atividade não se apresenta de forma transversal na equipe, com prática centralizada nos enfermeiros; maior domínio na execução do teste (tecnologia dura) e na abordagem informativa (tecnologia leve-dura); insegurança em relação à gestão de riscos e ao suporte emocional (tecnologias leves), principalmente diante do diagnóstico positivo. Um dos principais desafios para a eficácia do aconselhamento é a adequação da abordagem as necessidades do usuário.

Palavras chave: aconselhamento, HIV, testes sorológicos, atenção primária à saúde, descentralização

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Resumen: El estudio tiene como objetivo conocer y analizar cómo el asesoramiento en VIH / SIDA está desarrollándose en la descentralización de la prueba rápida para VIH y otras enfermedades de transmisión sexual para la atención básica. Se trata de un estudio cualitativo exploratorio, realizado en 15 unidades de salud de Porto Alegre/Brasil, a través de entrevistas con 22 profesionales. Los datos fueron sometidos al análisis temático y discutidos bajo la perspectiva del trabajo vivo en salud de Merhy. Se organizaron en dos temas principales: (1) La descentralización de las pruebas en la atención primaria; (2) Asesoramiento - elementos y desafíos. Los resultados señalados fueron: la actividad no se presenta de forma transversal en el equipo, con práctica centralizada en los enfermeros; mayor dominio en la ejecución de la prueba (tecnología dura) y en el enfoque informativo (tecnología ligera); inseguridad en relación a la gestión de riesgos y al soporte emocional (tecnologías ligeras), principalmente ante el diagnóstico positivo. Uno de los principales desafíos para la eficacia del asesoramiento es la adecuación del enfoque según la necesidad del usuario.

Palabras clave: asesoramiento, VIH, pruebas serológicas, atención primaria a la salud, descentralización

Received: 6/26/2017

Revised: 02/15/2018

Accepted: 04/16/2018

How to cite this article:

Bones Rocha, K., de Andrade Souza Ew, R., Moraes Moro, L., Lemos De Pinho Zanardo, G., & Pizzinato, A. (2018). Aconselhamento na perspectiva de profissionais da atenção básica: Desafios na descentralização do teste rápido HIV/Aids. *Ciencias Psicológicas*, 12(1), 67-78. doi: <https://doi.org/10.22235/cp.v12i1.1597>

Introduction

Counseling as a health care strategy in the context of HIV/AIDS emerged in 1988 with the implementation of Serologic Counseling and Support Centers, currently called Testing and Counseling Centers. Since then, testing and counseling have become crucial to prevention programs (Brazil, 1999). From that point on, new publications have discussed counseling (Brazil, 2003; 2005; 2008), in order to (re)conceptualize it, guide the requirements of emerging practices and contribute to the work of health professionals (Carvalho et al., 2016; Galindo, Francisco, & Rios, 2015).

Counseling is a tool that can be used in different educational and health programs (Souza & Freitas, 2012). It is characterized as a process based on active listening, establishing a trust relationship between professional and user, providing the user with conditions to recognize himself as an agent of his own health status. It consists of an exchange of information, emotional support, guidance and risk assessment, enabling the user to seek realistic solutions to face problems related to Sexually Transmitted Infections (STI)

(Brazil, 2003, Passos et al., 2013, Pupo, 2012). A systematic review of 66 studies considered counseling as a positive strategy that could influence the attitude towards infection and adherence to treatment (Soares & Brandão, 2012).

In 2005, the Ministry of Health (MS) issued Ordinance 34 (Brazil, 2005), which regulates the use of rapid tests for HIV diagnosis. The implementation of the rapid test is justified because it is an effective and reliable strategy, widely offered to the population through the Unified Health System (SUS), readily available and with a short waiting time for the result. In addition, it helps interrupt the transmission chain, preventing the disease from worsening, since 41% of the population starts treatment in advanced stages of AIDS (Brazil, 2005).

The rapid test does not require a complex laboratory structure, it is performed by collecting a blood drop and its result is obtained within thirty minutes. Its performance includes counseling as one of its stages (Brazil, 2016). Since 2000, the Ministry of Health has launched three manuals with guidelines for HIV / AIDS care in primary health care, highlighting the incentive for HIV diagnosis and the inclusion of counseling (Bra-

zil, 2003; 2005). Due to its characteristics and the high incidence of HIV/AIDS in Brazil, in 2012, the Ministry of Health proposed the implementation of the rapid HIV and STI test in the primary health care system (Brazil, 2012).

In relation to national studies on HIV/AIDS counseling, research focusing on pregnant and parturient women predominates (Passos et al., 2013, Carneiro & Coelho, 2013, Fonseca & Iriart, 2012, Silva, Tavares, & Paz, 2011). These studies criticize the way counseling is performed as it is mostly restricted to informing the diagnosis of STI in the pre- and postpartum period, with little attention to the autonomy of women in the decision-making process of testing, for example (Carneiro, 2010; Fonseca & Iriart, 2012). Researchers stress the importance of improving listening among health care professionals, emphasizing that pre-test counseling is not limited to obtaining consent for testing (Silva, Tavares, & Paz, 2011).

Due to the recent implementation of the rapid test in the primary care setting, few studies analyzing this situation have been found (Souza & Freitas, 2012; Araújo, Vieira, & Araújo, 2009; Araújo, Vieira, & Galvão, 2011; Henriques & Lima, 2009; Silva, Val, & Nichiata, 2010). The literature points out that primary care professionals recognize the importance of counseling as a care strategy, although it is often not performed as advocated in view of structural and operational factors (Souza & Freitas, 2012; Henriques & Lima, 2009; Silva, Val, & Nichiata, 2010). In this sense, it is important that studies be conducted to analyze the delivery of counseling and testing in the primary care setting, pointing out their potentialities and limitations, as well as the challenges that are posed to the cities that have decentralized or will decentralize the rapid test and counseling for primary care.

In this context, Porto Alegre, located in the state of Rio Grande do Sul, was one of the first cities in Brazil to begin the decentralization of the rapid test for primary care. This pioneering work is associated with the epidemiological situation of the city, since it is the capital city that registered the highest AIDS detection rate in 2016 (74 cases per 100,000 inhabitants), more than twice as high as the state rate (Brazil, 2016).

Considering the potential of counseling as a prevention and health promotion strategy, it is evident that studies on primary care counseling are needed in order to get to know the current context and identify good practices to create parameters and render systematic assessments feasible. Therefore, the aim of this study is to get to know and analyze how counseling for the rapid HIV test has been carried out within the decentralization process, from the perspective of primary health care professionals in Porto Alegre.

Materials and Method

This is a qualitative, exploratory, descriptive and analytical study. The survey was conducted in the primary health care system of Porto Alegre, which comprises eight district health managements. The Basic Health services with the largest and smallest number of rapid tests performed were identified- through a partnership with the Municipal STD/AIDS Coordination - and these were divided into two groups, with one center being drawn from each of the groups per management.

Data were collected in 2015 from 15 health services, these consisting of eight traditional Basic Health Units (BHU) and seven centers with Family Health Team (FHT). Among the drawn centers, one refused to participate.

Once the study was presented to the health services, each center indicated two professionals to answer the survey, totaling 30 interviewees. For this article, the interviews of 22 professionals who were trained by the City Hall to run the rapid test, according to the guidelines of the Ministry of Health, were used. The characteristics of the qualification process of primary care professionals for providing the rapid test and counseling are described in the article by Rocha et al. (2016). The participants were: nineteen nurses, a nutritionist, a gynecologist, and a dentist. Among these, only the physician and the nutritionist did not take the rapid test and did not receive counseling at the time, but they were trained.

The interviews lasted approximately 30 minutes and were recorded and transcribed in their entirety. In order to keep the identity of the participants confidential, the interviews were

identified as P1, P2 and so on, followed by the professional category, without mentioning the managements and the services of origin of the interviewees. The interviews addressed issues such as: knowledge about the rapid test and counseling; training process for primary care professionals; implementation of testing and counseling in the health centers and their relation to working conditions; the public seeking and being submitted to the test; and general assessment of the decentralization process.

For data analysis, Thematic Analysis according to Braun and Clarke (2006) was used. For this purpose, rapid testing and counseling were analyzed from the perspective of living work in health care (Merhy, 2002), considering the importance of the link between professional and user in the health care process. The steps followed in the analysis procedure were: a) transcription of interviews; b) initial codification of the most relevant topics on counseling; c) choice and definition of themes; d) re-reading and recoding of interviews; e) interpretation and organization of data, f) writing of the data analysis interconnecting analytical narrative and illustrative extracts.

This survey was funded by the National Council for Scientific and Technological Development (CNPq - Universal Announcement No. 482051 / 2013-2). It was approved by the Research Ethics Committees of the Pontifical Catholic University of Rio Grande do Sul (PUCRS) and the Municipal Health Department of Porto Alegre (SMS/POA). All participants signed an Informed Consent Form, observing the guidelines and standards regulating research involving human beings in accordance with the National Health Council Resolution no. 510 / 2016 (Brazil, 2016).

Results and Discussion

For the systematization of results, five categories were organized in two thematic axes. The first axis "Test decentralization in primary care" includes two categories: a) rapid test implementation process; b) rapid test and counseling dynamics. The second axis "Counseling - elements and challenges" presents three categories: a) informative and educational aspect; b) sexual practices and risk management; c) emotional support.

Test decentralization in primary care

Rapid test implementation process

Regarding the rapid test and counseling implementation process, all the participating services were observed to already have the test available in their routines, with its own dynamics in each center. Although the trained professionals had different academic degrees, in practice, the nursing staff was observed to run the tests. The speeches pointed to an unbalanced situation between training and testing in the services:

[Working process] "It's very difficult because it eventually falls to us only. The doctor refuses and that's all, so somebody has to do it. But we have another thousand things concomitantly. So I think there should be another person for this, or all professionals should be demanded to do it. If the patient is there in the office and the doctor thinks it's necessary to do the test, why doesn't he already do it? We have to worry from cleaning to a burnt-out lightbulb, so it's everything" (P5 - Nurse).

The professionals state that it is important that rapid testing and counseling could be carried out by all staff, but at the same time there is an understanding that it is difficult for other specialties to perform the test due to the specific demands placed upon those professionals. The professionals also complaint about the workload they have to take on, as they must conduct several health programs and policies in primary care. However, the increased demand is not accompanied with the corresponding enlargement of the staff, as noted in the following speech: "*activities are decentralized, but the number of employees doesn't increase. On the contrary, it has only decreased. So it's always the same people to handle it*" (P3 - Nurse).

Corroborating these findings, Souza and Freitas (2012) identified that primary care professionals attributed the non-performance of the test/counseling to the lack of available time, the dynamicity of the services and the multiple activities for the nursing staff. Similarly, Zambenedetti and Silva (2016) also characterized the work overload related to the several areas of activities under responsibility of the staff, as well as the existence of incomplete staff and turnover

of professionals, as some of the main problems and challenges that impact the decentralization of HIV/AIDS care. These factors are noted to directly impact the organization of the services as to the form of reception for testing and counseling. This fact often makes the staff choose a specific professional to handle testing, leading to the maintenance of a specialized logic in the services, whereby responsibility falls to only one professional and is not shared by the staff.

Regarding the way the rapid test procedure is organized, the Ministry of Health (Brazil, 2011) recommends that the service be provided on a walk-in basis. This strategy allows all users seeking the service to be received, broadening the possibility of carrying out health promotion and prevention actions. Of the 15 centers, three (20%) mentioned providing walk-in care, which is characterized by providing care for the user at the time he/she seeks the service; eight (53.3%) reported working under a mixed model, that is, with appointments and walk-in care at times, and four (26.6%) worked with appointments only. Scheduling was characterized differently, ranging from a specific number of daily appointments scheduled, distributed in one or two shifts per week, to fortnightly appointments.

In addition to the above, interviewees from four centers also pointed to infrastructure as a limiting factor for adherence to this service format. A few services had small rooms, without ventilation or acoustic isolation, and others did not have a specific room for testing, with shared spaces being used. As a professional explains:

"The room is not appropriate because it's a bit small, and I think the infrastructure isn't very good. As the room faces the front desk, they end up seeing that the person is coming in to take a rapid test. I think this is bad, if it was a more discreet place, I think it would be better" (P20 - Nurse).

These aspects are in agreement with the difficulties already pointed out by Fonseca and Iriart (2012) in a study about the delivery of counseling to pregnant women. The authors identified as limitations the lack of a suitable place to talk in privacy, the lack of professional qualification, and the staff operating under a logic of fragmented and discontinuous care production (Fonseca & Iriart, 2012). Therefore, it is necessary to reflect how these issues can impact the care process and delivery of counseling.

Rapid test and counseling dynamics

The testing and counseling process was analyzed from the perspective of living work in health care (Merhy, 2002), which looks at health care work from a relational perspective and analyzes the act of caring through three technologies: light, light-hard and hard. The test instrument, which involves the blood collection technique and the handling of the test kit, can be identified as a hard technology. Counseling involves the use of light-hard and light technologies, the former is related to the knowledge structured around the objectives of counseling and the characteristics and skills that a professional must have to carry it out. The latter concerns relational technologies, which involve the interaction between worker and user and encompasses the creation of a bond, acceptance, autonomy and the encounter of subjectivities. The light technology goes beyond structured knowledge, providing a degree of freedom in the choice of the mode of health care practice and production (Merhy, 2002).

The interviewees attribute the importance of the counseling tool to aspects related to light technologies, among them: to enable greater proximity and linkage between user and service, to enable user involvement in their own health care and to raise awareness about prevention.

"I think that this way the individual participates in the positive or negative diagnosis process of a certain disease. I believe that, according to the professional's approach, this is a way to raise awareness for prevention. Because one thing is when you go to a lab, you go there, collect blood, go away, and then you have the result in a system or go to the lab to get it. Another thing is when you participate from counseling right through to testing and the result. I believe this will be a way of raising awareness for preventive care". (P22 - Nurse)

As regards the configuration of the rapid test and counseling in primary care, three stages are recommended: pre-test counseling, testing, and post-test counseling (Brazil, 2003). However, it was noted that the professionals did not clearly define the difference between pre-test and post-test counseling. The interviewees explained that, before testing, information and clarifications are presented about the test, STI, forms of transmission and prevention. As for post-test counseling, the result is perceived as a milestone that will

guide what will be done at that moment. In case of a negative result, they explain what an immunological window is, and the need for using a condom is reinforced. When the result is positive, the user is referred for treatment.

According to recommendations of the Ministry of Health (Brazil, 2003), counseling should address educational/informational issues, sexual practices/risk management, and emotional support, both before and after testing. In this regard, it is necessary to analyze how these elements have been treated within the care process and in the delivery of counseling in Porto Alegre.

Counseling - elements and challenges

Informative and educational aspect

Among the topics making up counseling, all professionals describe the informative aspect as part of their approach, which includes: information on the test, infections, forms of transmission and prevention, application process and immunological window. Thus, the services emphasize, in pre-test counseling, the conveyance of general information and the recommendation for condom use.

It is important to highlight the importance of information in counseling, which has been carried out in accordance with the Ministry of Health guidelines (Brazil, 2003). The professionals often understand that this aspect should consist of a general script with topics to be mentioned to the user in a standardized way, as the following example:

*[Does everyone get the same counseling?]
“Look, I think they do. Maybe what might happen is: on a day you’re busier, you may forget to give some information. But I guess it’s pretty much the same for everybody”. (P20 - Nurse).*

Therefore, the informative aspect can be characterized as a light-hard technology (Merhy, 2002), since it concerns the structured knowledge internalized by the professionals through their technical training. Nevertheless, the conveyance of this established knowledge should be contextualized through the meeting with the user. A topic indicated by a few interviewees is the adaption of information to an easy language, considering the level of understanding of an individual.

In spite of this, no singularization was identified in informative approaches, as the transfer of a technical knowledge “package” is prioritized. Carneiro and Coelho (2013) state that this attitude would perpetuate an unequal relationship between professionals and users, making this interaction remain restricted to technical procedures. However, the informative and educational practice is a highly complex activity that requires the use of light technologies, such as the ability to customize the approach, considering the practices, beliefs and knowledge of subjects. When user uniqueness is taken into account, the user makes sense of the information, allowing greater assimilation. As emphasized by some authors (Barroso et al., 2011; Souza, Czeresnia, & Natividade, 2008), in addition to providing greater acceptance and a link between service and user, work is done to encourage user participation and autonomy.

Consequently, insofar as the user, as an active subject, is able to make choices and change his/her behavior, prevention can be effected (Passos et al., 2013). Thus, another aspect of counseling is introduced: risk assessment and management.

Sexual practices and risk management

The approach to exposure to infection risks is a relevant issue in the context of counseling. Talking about sexual practices with the user favors the identification of situations that are more likely to pose risks. This enables reflection and the establishment of new actions leading to prevention and minimization of aggravation. Working on this aspect is a way of recognizing user autonomy and enabling the creation of feasible self-care strategies to cope with risky situations according to the subject’s reality (Brazil, 2003; Carvalho et al., 2016; Passos et al., 2013; Pupo, 2012).

This type of intervention, which encompasses knowledge, attitudes and practices aimed at reducing sexual exposure and preventing STIs, in addition to adherence to treatment, is considered one of the most effective and safe approaches to reducing the risk of STI / HIV infection. It’s because requires smaller numbers of patients and relatively less time to assess expected benefits,

when compared to other behavioral and biomedical interventions (Kuchenbecker, 2015). According to Kuchenbecker (2015), even biomedical interventions requiring the use of drugs or other technologies requiring continued self-administration to ensure effectiveness (such as antiretroviral prophylaxis before and after HIV exposure) need to be associated with a counseling strategy involving effective communication and risk compensation reduction.

Of the 20 professionals who do testing and counseling, nine reported addressing the issue of sexual practices with users. However, four of these interviewees explained that this is addressed only when proposed by the user, either by expressing their doubts or reporting their experiences. In addition, the professionals felt that questioning the user about his/her sexual practices constitutes an invasion of privacy. These facts indicate difficulty in talking about the subject.

Furthermore, this may be associated with the maintenance of a hierarchical relationship, in which the user remains in a passive posture towards the professional who holds the knowledge, according to a study by Souza, Czeresnia and Natividade (2008). It should be noted that in order to identify situations posing a risk of exposure to infection, the professional needs to act as a facilitator so that the user can express himself/herself without judgment or embarrassment (Barroso et al., 2011), providing an environment in which the individual feels comfortable to reflect on his/her behavior (Carvalho et al., 2016). This environment comes into being through the professional's empathic attitude, listening to the user's needs and planning jointly what will be done.

"If the person feels open to report a situation in which he put himself at risk, then counseling changes, it delves further into it. Then it depends on the professional's openness". (P13 - Nurse).

"If you're taking the test, you have two possibilities: positive or negative. Are you ready for this? You don't have to deliver a speech on diseases. I think counseling has to be a chat, well focused, and make the individual feel at ease". (P10 - Nurse).

For this purpose, a way of coping with this difficulty may be through investing in skills with an emphasis on counseling as a relational action, in addition to the informational approach. This

strategy was also pointed out in a study carried out with matrix support professionals specializing in HIV/AIDS, who emphasized that training should provide an environment for sharing experiences (Rocha et al., 2016), and it can be developed through case discussions. In addition, matrix support actions using participatory and problematizing techniques can raise awareness and stimulate support and partnership between teams (CREPOP, 2008).

Another resource to handle this situation was illustrated by a service participating in the survey. This team prepared a questionnaire that poses in detail questions such as: sexual partners (men, women, both), type of sexual practice (oral, anal, vaginal), condom use and knowledge about sexual partner(s) (history of STIs, use of condoms and use of drugs), etc. According to the interviewees, this tool helps users express their doubts while responding to the instrument, potentially allowing users to be identified and reflect upon their practices.

Only two professionals reported having a more flexible attitude towards talking about sexual practices. They associate their technical knowledge with daily life experiences, allowing experiences of sharing with users.

"Now, what's counseling? Is it a lecture? No. I think counseling has to be a chat, well focused, and make the individual feel at ease". Here there's a female condom, there's a book, there's a penis [...] I even show [how to handle]". (P10 - Nurse).

Yes, I have no problem [talking about practices]. For example, homosexuality, anal sex, I have no problem at all. On the contrary, people have fun because I speak very openly about the subject and make jokes, I guess people like it. I get a lot of teenagers, too, so I make jokes and such, I talk dirty, and all that stuff". (P12 - Nurse).

However, this attitude is not observed to be a recurrent practice in counseling. In addition, most of the time the approach relies on the heterosexualization of care and an emphasis on reproductive health, that is, it is based on a care protocol that assumes that heterosexual practices and orientation are the norm, according to the following speech: "Counseling itself is general for everybody, even because the form of prevention

and the form of exposure is common to all” (P15-Nurse). Given this conception, the expression of the sexual practices of the user may be inhibited, and the service may be seen as unwelcoming, which may cause the user not to seek the health service again.

To ensure risk management, it is necessary for the team to create strategies that enable users to express their sexuality in order to help them think about forms of prevention that are feasible for their reality. In this sense, in a study with users submitted to testing, Barroso et al. (2011) identified that counseling enabled users to realize they were in a risky situation. Thus, the risk situation will be handled following the mapping of the situation, through which the user will honestly identify his/her limits to the adoption of preventive attitudes. For this to occur, counseling needs to be a moment of open dialogue without prejudice (Barroso et al., 2011).

Thus, the main identified challenge to counseling is to become an activity that encourages the user’s active role in his/her care process. Counseling will be accomplished once the degree of user vulnerability has been assessed, providing greater acceptance, full care, and emotional support. The last one is the third dimension of counseling.

Emotional support

Emotional support implies the team’s understanding that the user may be in a vulnerable situation, with the establishment of a trust relationship between professional and user being required. In this way, it allows an open dialogue about risky practices, the evaluation of possible scenarios and test results, and explores the support (social and emotional) network that the user can identify (Brazil, 2003). This support should be offered through an empathic approach and sensitive listening (CREPOP, 2008), facilitating the management of anxieties and fears, promoting reflection on the user’s emotional difficulties and seeking alternatives for overcoming (Barroso et al., 2011).

Interviewees mentioned emotional support in the counseling process. Only nine professionals reported addressing support-related issues and emphasized its importance in light of a positive result.

“We give news like that, and the person gets out of here out of his mind. Then we try, at least, not to let him go until you feel a bit sure that he won’t do anything stupid, that he understands, that he’s able to accept it”. (P6 - Nurse).

In this regard, the Ministry of Health (Brazil, 2003) advocates that emotional support be provided straight from the beginning of counseling, when the meanings and impacts of the possible serological results on the user’s life are discussed. Counseling without emotional support and professional involvement may become a hard technology, with a strict script and prescriptions (Galindo, Francisco, & Rios, 2015), which would characterize a technicalization of diagnosis (Zambenedetti & Silva, 2016) and, as a result, the user will not be able to undertake risk management. In this respect, only two professionals mentioned the importance of preparing the user to receive a positive result by working on the implications of the diagnosis:

“We have to wait for 15 minutes, during this time we talk, ‘are you ready for a positive result? How are you going to deal with this?’ And then, regardless of the result, I do counseling as feedback. If it’s negative, ‘it’s all right, but from now on take better care of yourself, so that you won’t have to come here and be afraid of doing it again’. I try, with this information, to see if they’re able to realize they need to take care”. (P8 - Dentist).

“There’s always the risk of being positive. Then, if the person is not ready, my work will be far heavier later. So I do it for the patient and I to be sure, for me to be able to handle it better afterwards”. (P4 - Nurse)

A survey conducted with professional advisors and users at a Testing and Counseling Center (Carvalho et al., 2016) found that, for professionals, the emotional support and bond created in the counseling are essential to help users perceive themselves in risky situations and prepare them for diagnosis. Similarly, users described this moment as an environment for reflecting upon their behavior and the disease impacts.

The interviewees speculated that knowing the characteristics of the different populations that are cared for facilitates a support approach. Therefore, a closer relationship strengthens the bond in order to personalize counseling.

“The bond helps a lot, because you already know that patient, you already know how to talk. If they’re hookers, a more vulnerable population, less knowledge, less education, then we customize, as far as counseling is concerned”. (P1 - Nurse)

However, despite being able to accomplish care according to the Unified Health System and primary care guidelines, counseling also encounters some difficulties and the resistance of professionals. On one hand, the interviewees stated that they feel empowered and secure in performing the technical part (hard technology), which involves administering the rapid test. On the other hand, 16 of them reported having difficulties to carry out counseling (light technology) in the face of a positive result. They mentioned feeling insecure toward the reactions of users following diagnosis, as they feel mobilized instead of prepared to handle this situation. For them, the practice of counseling evades predictability and a sequence of pre-established procedures.

It is understood that a positive result causes a stir among professionals who, at times, report not feeling comfortable to give news that they deem “bad”, due to the great impact that the HIV/AIDS diagnosis can have on the life of an individual. This stems from the fact that AIDS, in addition to being a chronic disease historically associated with death, carries social prejudice, often with the user being blamed. Given this, the lack of preparation to deal with the possible emotional reactions of the user, as reported by some professionals, may lead them to avoid performing the rapid test or result in outsourcing the management of these situations to other professionals who are considered specialized, such as psychologists and psychiatrists:

“I see in some workmates some difficulty, a fear of giving a positive diagnosis. Sometimes people even shy away from doing it or provide a few limits to access”. (P20 - Nurse).

It is important to understand that the emotional support offered in the service helps reduce the vulnerability of HIV patients and general users (Seoane & Fortes, 2009). Therefore, in addition to the points above aimed at dealing with these difficulties, it is noteworthy that the interviewees themselves mentioned that learning is

consolidated with practice. Through the support of colleagues who already carry out testing and counseling, by observing or discussing cared-for cases, and by the continuous attempt to improve the approach to the user. This what is found in the participant’s speech:

“I didn’t even know what the rapid test was. At the beginning, I always used to put myself in the patient’s shoes. Back then, I relied on her help [workmate], today I feel completely prepared. Look, you’re always in doubt, how am I going to show this to the patient, how am I going to say it? This always rears its head, but I wouldn’t say this is an insecurity, it’s more like a way of thinking better about how you’re going to say it”. (P15 - Nurse).

Therefore, it is necessary to provide professionals with spaces where they can get to know different resources so as to obtain tools and become available for counseling. Thus, the testing process, despite being named “rapid test”, requires time for its management. The hard technology which corresponds to testing and the confirmation of the test result, is rapid when compared with the laboratory process. However, the light relational technology, counseling, requires time and care from the professional. This is illustrated by the following speech:

“This person will be coming to take this test that is rapid. But this test isn’t that quick. It’s rapid because the result is released, and soon you can have a diagnosis, but it’s not rapid in management, in counseling. Because actually you’re going to have to persuade, you’re going to have to raise awareness, you’re not going to diagnose only. The period of individual consultation, of counseling, needs to be observed. So the word ‘rapid test’ should refer to a quicker diagnosis, and not to care”. (P22 - Nurse)

In addition to management and support after a positive result, it is also necessary to emphasize the relevance of the post-test step in light of a negative result. If the professional takes on a relieved attitude toward the non-detection of infection, he/she may disregard the information resumption step. As it is a period of lesser user anxiety, it is conducive to better fixation of the information made available prior to the test and allows the user’s understanding of prevention and risk management factors to be verified.

Final Considerations

In this study, it was possible to get to know and analyze how counseling for the rapid HIV test has been carried out within the decentralization process, from the perspective of primary health care professionals in Porto Alegre. This points to the relevance of this survey, since this topic is still scarcely explored in the recent context of decentralization.

It can be seen that counseling is regarded by professionals as an important tool for care and attachment to the user. However, a few aspects of this decentralization process impact the way it has been implemented. A logic of care fragmentation is evident, instead of dealing with care and the user as a whole, the professionals say that this is another policy that should be conducted. It was verified that the main issues reported by the professionals concern the testing process being centralized by the nursing staff, while this task could be shared with other qualified staff members.

Regarding the dynamics and structure of the health services, it is evident that an adaptation of the environment and routine of the teams, an increase in the number of professionals to meet the spontaneous demand for testing and counseling and broadening of comprehensive care are necessary. Appointments and the lack of a specific space for testing and counseling can impair the confidentiality and anonymity process.

As far as testing and counseling is concerned, although the professionals emphasized the importance of the counseling tool, they were observed to report greater easiness and mastery in testing (hard technology) and in the informative approach (light-hard technology). Regarding

risk management and emotional support (light technologies), the professionals reported feeling insecure, especially in light of an HIV-positive diagnosis. This question may signal to the understanding of counseling as something that actually took a back seat during the training of these professionals (Rocha et al., 2016) or of which the skills are specific to a professional's interactive ability or restricted to specialists.

Adapting the approach to the user's history is one of the main challenges to the efficacy and exploration of counseling. Besides the informational ability, it is important that this step take in user singularity as a starting point for developing joint prevention strategies, making him/her the kingpin in this care process.

Through this survey, counseling is identified as a complex tool. As with the literature discussed, it is necessary to consider that other interventions aimed at preventing and reducing the risk of infection, such as the use of drugs in different prophylaxis strategies, also presuppose the combination of counseling strategies aimed at behavior change, which reinforces the importance of this tool.

Improvement and investment in counseling are considered to be necessary for greater effectiveness of this care technology in promoting health and reaching out to the citizenry. To this end, investment in training and in the longitudinal arrangement of teams, through teams specialized in HIV/AIDS or Family Health Support Centers (NASF), is suggested as a strategic alternative for the capillarization of more qualified care. It is important to prioritize participatory methodologies that sensitize professionals and facilitate the discussion of cases and sharing of experiences.

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