



The integrality in Primary Healthcare: discourse analysis about the organization of the provision of the rapid anti-HIV test

Integralidade na Atenção Primária: análise do discurso acerca da organização da oferta do teste rápido anti-HIV

Integralidad en Atención Primaria: análisis del discurso sobre la organización de la oferta de la prueba rápida del VIH

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ABSTRACT

Objective: Analyze health managers discourse related to the organization of the rapid anti-HIV test provision, from the perspective of the integrality attribute. **Method:** Exploratory research of qualitative nature, undertaken in a health district of the municipality of João Pessoa, Paraíba. Data collection was carried out in September 2017, using a semi-structured interview script for a semi-structured interview, which was applied to thirteen health care service managers from Primary Health Care services. The empirical material was analyzed in the light of the theoretical-methodological Discourse Analysis device, identifying the discursive block: Organization of services for conducting the rapid anti-HIV test. **Results:** The speeches point out to the ideological affiliation that comprises the fragmentation of the assistance, standardization of the demand with focus on schedules, stigmatization and unaccountability of the care, making it difficult to achieve comprehensiveness in the perspective of the decentralization of the offer of rapid anti-HIV test. **Conclusion and implications for practice:** The discourse of health managers points out weaknesses in the quality of service and organization of the rapid anti-HIV test provision. Implementing policies to reverse the current situation and continuing education for professionals can enhance the integrality of the service.

Keywords: Primary Health Care; HIV; Early Diagnosis; HIV Infections; Integrality in Health.

RESUMO

Objetivo: Analisar o discurso dos gerentes saúde relacionado à organização da oferta do teste rápido anti-HIV, na perspectiva do atributo integralidade. **Método:** Pesquisa exploratória de natureza qualitativa realizada em um distrito sanitário do município de João Pessoa/PB. A coleta de dados foi realizada em setembro de 2017, utilizando-se um roteiro de entrevista semiestruturado, o qual foi aplicado a treze gerentes de saúde de serviços de Atenção Primária à Saúde. O material empírico foi analisado à luz do dispositivo teórico-metodológico de Análise de Discurso, identificando-se o bloco discursivo: Organização dos serviços para a realização do teste rápido anti-HIV. **Resultados:** Os discursos apontam a filiação ideológica que compreende a fragmentação da assistência, normatização da demanda com enfoque em agendamentos, estigmatização e desresponsabilização do cuidado, dificultando a realização da integralidade na perspectiva da descentralização da oferta do teste rápido anti-HIV. **Conclusão e implicações para a prática:** O discurso dos gerentes de saúde aponta fragilidades na qualidade do serviço e organização da oferta do teste rápido anti-HIV. Executar as políticas para reverter a situação atual e a educação permanente dos profissionais podem potencializar a integralidade do serviço.

Palavras-chave: Atenção Primária à Saúde; HIV; Diagnóstico Precoce; Infecções por HIV; Integralidade em Saúde.

RESUMEN

Objetivo: Analizar el discurso de los gerentes de la salud relacionados con la organización de la oferta de pruebas rápidas anti-VIH, desde la perspectiva del atributo de integralidad. **Método:** Investigación exploratoria de naturaleza cualitativa, realizada en un distrito sanitario del municipio de João Pessoa/PB. La recogida de datos se llevó a cabo en septiembre de 2017, utilizando un plan de entrevista semiestructurada, que se aplicó a trece gerentes de la salud de servicios de Atención Primaria de la Salud. El material empírico se analizó a la luz del dispositivo metodológico teórico del Análisis del Discurso, identificando el bloqueo discursivo: Organización de servicios para realizar la prueba rápida anti-VIH. **Resultados:** Los discursos señalan la afiliación ideológica que incluye la fragmentación de la asistencia, la normatización de la demanda con enfoque en los horarios, la estigmatización y la irresponsabilidad de la atención, lo que dificulta alcanzar la integralidad desde la perspectiva de la descentralización la oferta de prueba rápida anti-VIH. **Conclusión e implicaciones para la práctica:** El discurso de los gerentes de la salud señala las deficiencias en la calidad del servicio y la organización de la oferta de pruebas rápidas anti-VIH. La implementación de políticas para reverter la situación actual y la educación permanente de los profesionales puede potenciar la integralidad del servicio.

Palabras clave: Atención Primaria de Salud; VIH; Diagnóstico Precoz; Infecciones por VIH; Integralidad en Salud.

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INTRODUCTION

Currently, it is known that there are advances in dealing with the Human Immunodeficiency Virus (HIV), but not every user has equal access. It has been seen that, over time, such infection has always been permeated by stigmatized conduct and practices, distancing the user from early diagnosis and weakening the health policies developed in response to HIV.¹

According to *The Joint United Nations Programme on HIV/AIDS (UNAIDS)*, in 2018, there were 37.9 million cases of HIV worldwide, 36.2 million of which were in adults and 1.7 million in children under the age of fifteen.²

In Brazil, in 2018, 43,941 cases of HIV infection were reported by Sinan. Of these, according to sex, 207,207 (69.0%) were men and 93,220 (31.0%) women. The region with the highest concentration is the Southeast, followed by the Northeast and South with 16,586 (37.7%), 10,808 (24.6%) and 7,838 (17.8%) respectively, followed by the North region with 5,084 (11.6%) and 3,625 (8.2%) in the Midwest region. It is known that compulsory underreporting of HIV makes it difficult to better evaluate cases of infection in Brazil and directly interferes with the implementation of public policies to better manage the care of this grievance.³

The outbreak of HIV/AIDS in Brazil was a concomitant landmark in the confrontation of political, economic and social decline, characterized by the change in the Brazilian democratic leadership and the triggering and restructuring of numerous social mobilizations, in which the Brazilian government has been implementing actions and services aimed at reducing the incidence rate of AIDS in the country.⁴

Among these actions and services, the decentralization of the anti-HIV Rapid Test (RT) stands out as an immediate response to the demand for HIV/AIDS cases, in addition to expanding access and forming the link between professional and user, since Primary Health Care (PHC) is recommended as the gateway to the Single Health System (SUS), being consolidated as an ordering axis, in which this insertion of diagnostic provision has expressed a new face of health policies, detaching from the centralized process for the consolidation of a decentralized model.⁵

PHC is operationalized through four attributes that aim to discuss the quality of care and its organization, presenting, among these, the attribute integrality as a defining characteristic of the PHC service and the guiding principle of the SUS, which aims to enable the organization of the RT anti-HIV provision and ensure permeability at all levels of the health system, according to the user's needs.^{6,7}

In this way, integrality is interpreted through a collective construction, as it presents meanings represented by 'integrality as a feature of good medicine', 'integrality as a principle/mode of organizing health practices' and 'integrality as government responses to specific health problems'. This study will address integrality as a way of organizing health practices, which can be understood as the need for horizontality and greater reach of health programs and policies, as well as the inclusion of preventive care and practices, with a view to overcoming the fragmentation of practices in health facilities.⁷

In 2004, the Ministry of Health (MH) legitimized the anti-HIV RT in PHC as a method of control and prevention of infection in order to more effectively embrace social actors who are vulnerable to infection, enhancing the proposal through Ordinance No. 29 of 17 December 2013, which favors a change in actions in HIV control, in addition to bringing the provision of RT anti-HIV to the user.^{8,9}

Copious are the problems in PHC, obstacles that make it difficult to achieve the decentralization of the RT anti-HIV, which requires gradual inclusion of this decentralization, understood as an action that is difficult to incorporate into PHC attributed to the stigma of the disease, the provision of the test in the gestational period and the fragmentation of care, which consequently compromise the quality of health services in reference to the management of infection based on the attribute integrality, for the granting of parameters that help in decision-making about current policies.^{8,10}

The understanding of the problem described presents the proposal of this study, which arose from the need to understand the process of decentralization of the RT in the PHC services from the discourse of the health managers responsible for conducting the implementation of health policies and programs and, consequently, to analyze the organization of PHC and its influence in ensuring the completeness concerning the provision of the RT anti-HIV.

No studies have been identified that deal with the organization of health services in PHC for RT anti-HIV, especially with the discourses of health managers as the focus of research. Thus, the question is: How do health managers of PHC service teams organize the provision of RT anti-HIV? The objective of this study is to analyze the discourse of health managers related to the organization of RT anti-HIV provision, from the perspective of the integrality attribute.

METHOD

A qualitative exploratory research conducted with the Health Managers of the PHC services in a Health District of a municipality located in the eastern region of the state of Paraíba. This Health District was chosen because it covers and concentrates the largest number of users who access the RT anti-HIV.

The Health Manager Program is supported by the National Basic Care Policy (NBPC), established as a standard by the MH and the World Health Organization, becoming a reference for all Brazilian municipalities.¹¹

As a criterion for the inclusion of the subjects, it was considered the situation of acting as a manager in the local health system, represented in the figure of the health managers, excluding from the research the health managers who were distant from their service, being applied the technique of theoretical saturation, in which as the interviews were carried out, a continuous process of data analysis was performed, individually, identified by the distancing of new elements in the discourses.

Thirteen professionals from these services were interviewed, including four physiotherapists, four social workers, two speech

therapists, two physical education professionals and one administrator.

The data collection was carried out in September 2017, in an environment chosen by them, with all the interviews being conducted in the services of the manager participating in the study. The interviews were conducted in the morning and afternoon shifts, individually, in a reserved room, by signing the Informed Consent. A semi-structured interview script was used, with questions related to the subject of the study.

To obtain the empirical material, the interviews were recorded by means of a smartphone, with an average duration of 20 minutes, being later transcribed in full. In order to preserve the image of the collaborating subjects, the names were replaced by the acronym G alluding to the managerial name, listing it in the sequence of the interviews, that is, G1 to G13.

In order to expose the character of the historical context, maintaining as a common element the centrality of discourse and highlighting the possible observation of it from different perspectives, the theoretical-methodological device of Discourse Analysis (AD) of French line was used.¹²

The French DA interprets language as a social practice, based on a subject from the unconscious, emphasizing that it does not seek a right or wrong answer, but rather seeks to expose what it is and how it works.¹³ Bearing in mind that thought practices are exposed through discourses, the French DA reserves the function of elucidating the process of construction through the language.

In the data analysis, the initial stage takes place in the circumscription of the concept-analysis, having, as scope of the analysis, the saturation determined by the recurrence of discourse to the point of being closed. At that moment, it will be fomenting the corpus. After the definition of the corpus, there is the floating reading done without significant emphasis and then the analytical reading to help the analyst to highlight the senses that answer the three heuristic questions: 1. What is the concept-analysis present in the text? 2. How does the text construct the concept-analysis? 3. To which discourse does the concept-analysis belong constructed in the way the text constructs?¹³

For the interpretation of the study corpus, the analysis-concept "*Organization of the provision of RT anti-HIV*" was used. Next, we sought to identify the meanings attributed by health managers about the organization of PHC services for the provision of RT anti-HIV by means of exhaustive readings, identification of textual marks until there was saturation of senses. Therefore, we sought to locate the meaning constructed by the health managers about the object of study, highlighting the functioning of ideology in textualization.

The second stage is defined by the writing of the analysis: characterization of the analysis through contextualization and explanation of the theme from what it will be treated; explanation of the theoretical-analytical device.¹³ Thus, it was possible to identify the following discourse block: *Organization of the health service to perform the RT anti-HIV*.

The research project was sent to the Research Ethics Committee-REC of the Faculty of Nursing and Medicine Nova Esperança-FACENE/FAMENE, under protocol number 108/2017 and CAAE number: 72757817.6.0000.5179, contemplating the legal and ethical guidelines, respecting the research protocol involving human beings, contained in resolution 466/2012 CNS/MS.

RESULTS

The discourse block *Organization of the health service for the realization of the RT anti-HIV* was formed by means of statements and respective discourse fragments of health managers regarding the organization of the provision of RT anti-HIV in PHC, presented below (Chart 1).

DISCUSSION

Through the fragments, situations were seen that affect the completeness of the care, weakening the organization of the provision of RT anti-HIV regarding: organization of PHC, accessibility, training of the health professional, transfer of responsibility, organizational devices, stigmatization, lack of familiarity regarding completeness and fragile joints.

Thus, the scope of the discursive analysis was the organization of the provision of RT anti-HIV through the attribute completeness. It is known that completeness is understood as a collective and controversial construction in its meanings, the discourses made it possible to identify the principle/mode of organizing health practices completeness, emerging the need for horizontality to implement what the MS recommended for the provision of RT anti-HIV.¹⁴

Local management recognizes that RT anti-HIV is an PHC assignment, decentralizing the diagnostic flow of the Test and Reception Center (TRC) and the scope of reference for treatment, fulfilling what is recommended by SUS organizational guidelines. Thus, ensuring the organizational flow, this segment becomes essential for the accomplishment of the RT anti-HIV in the municipality under study.

The discourses expose a situation that potentializes the user's demand for specialized services for diagnosis and treatment, since current policies to confront HIV introduce a proposal to decentralize HIV control actions in PHC in order to increase the permeability of health services in a way that favors the confrontation and control of HIV.¹⁵ The meaning attributed to the discourses of health managers refers to the fact that users should go to specialized services to obtain the diagnosis, perhaps because these units have trained professionals and an adequate structure to attend to users and, at the same time, are outside the competence of PHC due to the lack of qualified professionals or provision of the test.

The managers report that they do not perform the RT because the professionals are not interested in the training, making it impossible to perform the test in PHC, which makes the user susceptible to late diagnosis, impairing the operationalization of the RT anti-HIV, in addition to emphasizing the importance of

Chart 1. Discursive cut of health managers in relation to the organization of services in the provision of RT anti-HIV in PHC. João Pessoa, PB, Brazil, 2017.

Formulation	Discursive fragments
Organization of the PHC in the provision of RT anti-HIV	<i>This was to be known by the team, unfortunately this I speak in a general way, not only here I put myself inside these people, we do not know much about the flow of the municipality [...]. (G13)</i>
Accessibility to the RT anti-HIV	<i>Here at the unit we don't have the quick test, because we don't have those professionals [...](G1)</i>
Health professional training for the provision of RT anti-HIV	<i>Here at the unit there is no rapid test, because only people who have the training to [...] none here have the training to do the rapid test, in fact, none of them were interested [...]. (G6) [...] We don't have the trained professionals yet, [...] we have professionals from another health team that they come to support when these actions are carried out sporadically [...]. (G8)</i>
Transfer of responsibility for the carrying out of RT anti-HIV	<i>[...]she refers to the nurse of the unit she makes, which is the one she has, already with the result he is referred to his reference team, together with the doctor and the nurse, they give the referral. (G2) [...]she [nurse] will make the notification and forward to receive the cocktail. (G9) [...] when she [nurse] identifies she refers to the Test and Counselling Center (TCC) [...] (G10)</i>
Distance from Longitudinality	<i>[...]Our unit on Monday is scheduled for Friday, for users to come and do on Friday [...]. (G7)</i>
Organizational devices	<i>[...] Before we used to make appointments and when they were missing, now it's being demanded freely, [...] there are in the waiting room, there are actions, in actions it's very requested. (G5) Prevention activities are carried out, always focused and stimulated in the waiting room [...] The confrontation is done in this sense also in the active search of patients who have and seek the service [...], [...] the day is scheduled and sometimes also spontaneous demand, is offered in these units which are references [...] (G12)</i>
Stigmatization of people living with HIV/AIDS	<i>[...]we only mislabel as HIV positive, we only mislabel as a person who has HIV and I believe that this type of user I refer him to Clementino (reference hospital) for treatment [...] (G13)</i>
Lack of familiarity regarding the completeness of the provision of RT anti-HIV	<i>[...] they do with the pregnant women who are already part of the routine exams they do, as they do with the so-called risk groups [...] with this issue of pregnant women. (G3)</i>
Fragility in the articulation between the points of attention	<i>[...]he already knows where to refer the nurse or doctor already directs him to a specific place of treatment [...]. (G4) It's not offered here, if we were you, I'd refer you. (G6) [...]she will make the notification and forward to receive the cocktail. (G9) [...] he was referred to Clementino (reference hospital), [...] the part which refers to cocktail is all forwarded there [...], he does the test if he is positive and we send him straight there. (G11)</i>

the presence of management in the implementation of the test, with the purpose of accommodating the demand of the members, with emphasis on privacy and ethics.¹⁶

Following the line of interpretation of the meanings, health managers attribute to the other, in this case, to health professionals, the lack of interest in the qualification for the provision of the RT anti-HIV in the PHC. In this perspective, there are indications that

the discourses point to the lack of responsibility of professionals in providing the exam.

The discourses reveal the transfer of responsibility for identifying and referring HIV-positive users to the nurse. The discourse sequence “she [nurse] will make the notification”; “she [nurse] identifies [...] and refers to the TCC” outsources responsibility only to a professional, which signals fragmentation of care.

It can be observed that the assistance is centralized in specialized assistance. The fragmentation of care is related to the disarticulation of intersectoral communication, knowing that it is important to articulate between the three levels, requiring the implementation of Health Care Networks (HCN) which represents a problem in the national and international context. In addition, the centralization of care represents discontinuity and contributes to professional inaptitude, favoring the fragmentation of care and distancing it from a resolute action.^{17,18}

In other statements, health managers reveal meanings that indicate barriers to the performance of RT anti-HIV in PHC services, when they present textual marks such as *"it is not done in this unit," "only people who have training can do the rapid test,"* and *"it already directs it to a specific location"* favors the search for specialized services, going against the policy of decentralization of HIV diagnosis in PHC.

In this sense, the results presented here do not reflect only a local reality, since the study conducted on PHC in eight Basic Family Health Units (BFHU) also identified barriers to perform the RT in the health units, highlighting the lack of any interest in creating a user/professional bond, and even less, in the quality of care. In another study, it was seen that in the opinion of the users interviewed, the relationships of professionals are non-binding, that is, there is absence of resolution, delay in appointment, consultation and waiting in line.¹⁹

From the discursive sequence *"in our unit, in the second one is scheduled for [...] the users to come and do on Friday"* produces indirect senses of the difficulty of the users to perform the exam and fragments as *"they [the nurse] do with the pregnant women who are already part of the exams [... As they [nurses] also do with the so-called risk groups"*, a service organization for RT anti-HIV is revealed, aimed at limiting the supply, specified by the demand for risk groups and specific care, pointing out barriers that weaken completeness due to the distance from the creation of the necessary bond and welcome to provide RT anti-HIV.

In the G3 speech the central point of the RT anti-HIV provision is directed to pregnant women, excluding the other population segments. When interviewing the teams, the delimitation of the public was revealed only for pregnant women, since the RT is already part of the routine of prenatal testing requested.⁵ On the other hand, the barrier in providing RT anti-HIV to other individuals in the community is linked to sexuality and morality associated with HIV. In addition, there are bottlenecks in the number of units that have been tested for HIV, but the study reveals that acceptance for the test is high, emphasizing that the availability of HIV testing optimizes access, requiring only the organization of the offer.²⁰

Still on the discourse, without realizing it, the health managers showed through discursive memory, senses and meanings that point to a service organization that hurts the longitudinality, called continuity of care. In this way, it contributes to the creation of trust, interpersonal bonds between professionals and users, which favor the provision and performance of the test. And, in this logic, if the HIV test is positive, the user needs to permeate the service, in addition to avoiding unnecessary referrals to

specialized services, making longitudinality contribute to the creation of corresponsibility between professionals and users over time.^{21,22}

Longitudinality enhances the completeness attribute, aiming at early and accurate diagnosis in order to initiate Antiretroviral Therapy (ART), as seen in a study conducted in South Africa, in which ART is provided in PHC and prescribed by professional nurses in HIV management, to decrease the viral load in blood circulation, which consequently decreases the spread of the virus.²³

Organizational devices have emerged in the discourses that optimize the RT provision strengthening the attribute of completeness, such as: waiting room and active search, according to the discursive sequences - *"prevention activities are done [...] in waiting room care, [...] active search of patients who have and seek the service"*. Thus, the waiting room constitutes an optimizing space for users to report their daily experiences, reflect on the health-disease process and be sensitized to perform anti-HIV testing.²⁴

The active search present in G12's discourse alludes to patients seeking unity, that is, spontaneous demand, in which the textual mark is sharpened in the discourse constructed by the memory of the senses *"[...]the day is scheduled and, sometimes, also spontaneous demand, is offered in those units which are references[...]"*. This organizational arrangement refers to the unscheduled service, since it only contemplates momentary needs, referring to a work process focused on biomedical assistance, whose interventions are only carried out when the user seeks the health unit. It is known that the assistance model, where organizational actions are permeated by spontaneous demand, with scope in the cure, causes a departure from the current model, which is prevention and health promotion.²⁵

The discursive fragment through the textual marks *"is scheduled the day, and sometimes spontaneous demand"* enhances the distance from the reception considered a very important tool for creating a bond with the user, providing interpersonal ties that reflect reciprocity between professionals and users, in order to rethink the health care and strengthen the integrality, so that the user feels welcomed and safe to do the TR anti-HIV.²¹

Thinking about the fragmentation mentioned above, a study points out completeness as the key of the sample, bringing to light that such attribute is comprehensive and transcends the access to network points, that to guarantee the longevity of the user in the health service, it is necessary to have a commitment with the quality of the assistance provided. Thus, contemplating completeness in PHC is a challenge, and professionals must understand the local reality in order to create new interventions and break with this model centered on the disease, which still prevails at this level of attention, seeking health promotion, protection and recovery.^{26,27}

In the G13 segmentations, a discourse linked to the historicity of HIV emerged, sharpened in the textual marks *"we only mislabel as HIV positive," "we only mislabel as a person who has HIV,"* and *"I believe this type of user"*. Such discourse is justified as discursive memory alluding to the stigmatization of people living

with HIV/AIDS recovered by discourses already mentioned, renewing the historicity of discursive success, being materialized by the social memory established in historicity.²⁸

The stigma and discrimination associated with HIV/AIDS, referred to by users in PHC services, were seen in a study, and professionals recognize their own prejudice and praise this same sentiment by users themselves.²⁸ This fact can be understood by its historicity, since in the past, people with HIV were labeled by their risk group, such as sexual orientation, or by risk behavior such as drug use or sex workers. Today, even as the infection has evolved, stigmatization is still present in society and among health care professionals, and there are reports of studies in which individuals with the virus have been refused assistance in revealing their condition.²⁹

From the discourse of G3 and G13, it is evident that, in the current context, integrality is out of reach, being predominantly directed to pregnant women, leaving the other members unassisted, which potentializes the fragmentation of care. The MH advocates assistance at the primary level of equitable and collective attention with the expectation of holistic attention, since completeness is a primary factor that favors continuous care to people living with HIV/AIDS.³⁰

Although the decentralization of RT anti-HIV in APS is a policy to be implemented in services, the discursive fragments reveal textual marks such as *“he already knows where to refer”*, *besides “some user who has some symptom”*, *“even in case of sexual abuse these things”*, *“reference to Clementino (reference hospital)”*, *“she will make the notification and refer to receive the cocktail”*. It is observed in the oratory the distancing of the user in carrying out the exam, performing it only through clinical aspects. The user is automatically directed to the hospital referral service, and the hospital-centered hegemony, whose care are based only on symptoms already in place, guided by hospital care, instead of using PHC as a preventive level. Still in these discourses, it is evident that the health manager is unfamiliar with the user's path in Health Care Networks (HCN).²⁸

Completeness passes through the other levels of care, however, it is in PHC that its greatest strategic significance is found due to the resoluteness and need to respond to users, family and community.²² Thus, the management of the diagnosis of infection has been directed to PHC because of the possibility of greater permeability and continuity of quality care, since it is responsible for coordinating and ordering care in its area of coverage.²⁰

HCN have been designed by the MH with the perspective of restructuring and, especially, overcoming the fragmented model of management and health care, in order to ensure the actions that users need. HCN are comprised as a system of multiple health services, seeking to offer integral and continuous care to those who are enrolled, and should be coordinated through the PHC through lines of care.³¹

It is understood, therefore, that the organization of the service to the provision of RT anti-HIV at the primary level of care does not converge with the attribute completeness insofar as there is a distancing from

the discourses of managers in relation to that recommended by the SUS guidelines. From this perspective, the discourse that sustains the meanings of organizing the provision of RT anti-HIV in PHC services, from the health managers, is the hegemonic discourse, with a biomedical and hospital-centered characteristic, since the scope is in providing the test to pregnant women and in referring users to the specialized or referral hospital services of the municipality in order to obtain the detection of HIV infection.

CONCLUSION AND IMPLICATIONS FOR PRACTICE

From the representational delimitation of the RT anti-HIV in this study, it was observed that the discourses point to weaknesses in the quality of the service in terms of organization and the exercise of the completeness attribute referring to the provision of the test, permeated by basic barriers in the management of care such as the non-appropriation of its position as a potentiating agent in the detection and notification of cases, in addition to the lack of regular contribution of the patient to PHC and its continuous use over time, from the perspective of the implementation of health policies concerning HIV/AIDS. This condition requires apprehension and carrying out of policies in order to reverse the current situation of the grievance.

It stands out, as the main limitation, the restriction of the research subject to the health manager, leaving aside other professionals who work directly in the provision of RT anti-HIV, such as nurses and physicians, elucidating only the experience of one professional and not all who are in the production of care for people exposed to HIV. However, elucidating the discourses of health managers is strategic for understanding the organization of the provision of RT anti-HIV in PHC services, since this professional performs administrative functions capable of changing a given reality, both from the perspective of restructuring the health service and the qualification of human resources.

Thus, we verify from the material analyzed, that the discourses point to the ideological affiliation that comprises the fragmentation of the care, standardization of the demand with focus on schedules, stigmatization and unaccountability of the care, making it difficult to realize the completeness with emphasis on the decentralization of the supply of RT anti-HIV.

Therefore, it is suggested the production of other studies that understand the inclusion of health managers and also other participants as professionals and users, since this current situation refers to the need for training, greater institutional and political incentives related to continuing education in the daily lives of professionals as an instrument for change in social practices, in order to enhance the completeness of the service and implement policies to reverse the current situation of the grievance.

AUTHORS' CONTRIBUTIONS

Study design. Acquisition, data analysis and interpretation of results. Writing and critical review of the manuscript. Approval of the final version of the article. Responsibility for all aspects of

the content and completeness of the published article. Haline Costa dos Santos Guedes. José Nildo de Barros Silva Júnior.

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Provision of the rapid anti-HIV test

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