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The education for facing the HIV Epidemic

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The objective of this study was to analyze the physicians' perception regarding the building of new knowledge about the initial management of the user with reactive rapid HIV test in Primary Health Care. The teaching methodology was the problematization methodology using the modality of distance learning. It is a critical action-research in a reflexive process through an interactive educational module offered in the Specialization Course of the the Open University of the Brazilian National Health System-SUS/Federal University of Health Sciences of Porto Alegre (UNASUS/UFCSPA). The discourses are distributed in three categories of analysis: practice scenarios, comprehensive care and continuing education. In the analysis, the apprehension and the commitment to reality, associated with the theorizing, generate a reflective plan of conduct. According to the 90-90- 90 target, there is an expectation to broaden diagnosis; however, it is necessary to make an expanded reading of the practice of disclosing the result of the test.

Keywords: Distance learning. HIV. Health education.

Introduction

Compulsory notification of HIV infection is very recent in Brazil, which precludes a rigorous epidemiological analysis regarding the trends of this pathology. The number of notifications between 1980 and June 2016 was 842,710 cases of AIDS and between 2007 and June 2016 there were 136,945 cases of HIV infection[1]. The current scenario shows a trend to reformulate public policies. UNAIDS is aiming to eradicate the HIV epidemic worldwide by 2030, through the proposal of the plan for the Triple Target 90-90-90. This agency forsees the definitive and ambitious target that by 2020, 90 percent of all people living with HIV will be diagnosed, 90 percent of them will receive antiretroviral therapy without interruption, as well as 90 percent of those receiving treatment will have viral suppression[2]. Several Brazilian municipalities have already committed themselves to achieving these targets. The Federal Medical Council, through Recommendation No. 02/2016 reccomends professionals to request tests for HIV, Syphilis and Hepatitis in the consultations, accompanied by pre and post-test counseling and referrals for consultations when necessary[3].

Some strategies to achieve diagnostic goals are the public campaigns to stimulate rapid testing for sexually transmitted infections. Thus, health professionals need to have a community approach to receive the patient and disclose the diagnosis, especially within Primary Health Care (PHC), due to its principles of accessibility, resolution and longitudinality in the work process[4]. Considering the context of the Rapid Test (RT) decentralization and the expansion of access to treatment, some qualitative research is taking place in Brazil to evaluate the way this process is developing. In Rio de Janeiro, the research involving the training course and practice of counselors in RT showed that it is essential to promote dialogues regarding the recommendations of the guidelines, relating to local knowledge, the team's interdisciplinary way of acting and the point of view of the user[5].

The PHC team has a chance to explore the opportunity to advise on changes in risk behavior or harm reduction and to make an early diagnosis whenever applying the

test[6]. The process of permanent education makes it possible to update the content and to modify reflexively the professional practice, in an expanded reading of care production, with user humane reception and accountability[4]. The 90-90-90 target includes, in addition to the numbers, a human rights-based approach[2]. In the contextualization of the facts, with their multiple determinants, the health team can enlarge their competences in order to plan the action in its territory through the perception and reflection on the real need of its users[7].

In the context of the possibility of using permanent education in health as a tool to support the 90-90-90 target, this article aims to analyze the perception of physicians to build new knowledge about the initial management of the patient with rapid test positive for HIV through the use of the Problematization Methodology (PM), in the modality of Distance Learning (DL) to transform their reality in PHC.

Methods

This is qualitative research of an applied, exploratory nature, with a convenience and non-probabilistic sample, being an action-research carried out with physicians who attended the Specialization in Family Health at UNASUS/UFCSPA and who spontaneously chose to study the Module "Initial Management of Users with Rapid HIV positive Testing", with the objective of addressing comprehensive care, improving knowledge about the pathology, and improving the flow of first steps management within the possibilities of their health units and of the service network. The opening of vacancies was offered to the two groups that were already in the second stage of the Specialization, called "Core", due to the fact that they were already acclimated to learning from complex cases. The estimated workload was 8 hours and the availability was in the first quarter of 2016. The course is integrated in the platform Repository of Educational Resources in Health (ARES), under the register 3474. Available at: https://ares.unasus.gov.br/acervo/handle/ARES/3474

Berbel[8], a Brazilian researcher who created the PM, relates that groups of 11 to 13 individuals provide the opportunity to deepen the discussion of problem situations. Our study included 14 students (identified with the letters of the alphabet from A to N, and their cities were omitted to ensure confidentiality). The PM is one of the active teaching methodologies, regulated by Ordinance No. 278 of February 27, 2014 by the Ministry of Health. These methods are employed in the process of permanent education in health by stimulating meaningful learning by a specific pedagogy, addressing the demands of learning development that (re) signify the reality. A research that interviewed experienced medical educators showed that they recognize that scientific knowledge is also constructed through experience and that its nature depends on the forms of acquisition and their interpretation[9]. The knowledge is elaborated according to a personal order based on their experience. It is generated and shared culturally, and goes through constant transformation. The purpose of the PM teaching methodology is aligned with that of the research methodology, action-research, which aims to transform the practice through the inclusion of subjects in a proactive, innovative and interventionist way[10].

The problematization can aid in the development of skills that involve solving impasses and promote the development of critical and reflective thoughts. The PM is structured in five consecutive steps, having the basis in Reality: Observation of Reality, Survey of Key Points, Theorization, Solution Hypotheses and Application to Reality[11]. Its adaptation in the educational module for distance learning was a challenge, since originally the PM was developed for face-to-face activities. The activities were distributed according to the methodological principles of the PM[12]. Below is the representation of this organization.

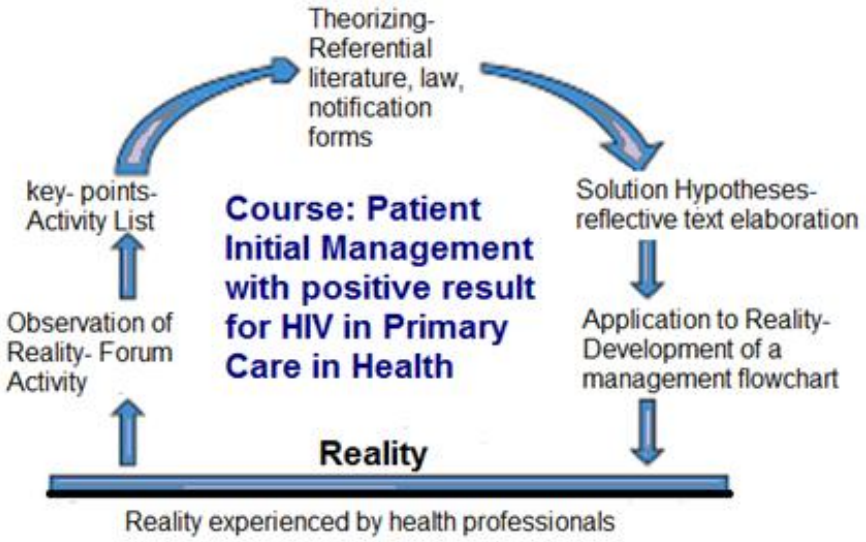

Figure 1– Activity planning following the PM steps.

Source– Author.

In the premise of the MP, there were relevant questions about the circumstances as experienced, to understand and to know how to handle them[13]. The guiding questions were in the Reality stage (see Figure 2), to be discussed in the forum: "Have you already disclosed to a user the reactive result for the HIV virus in your professional practice? What initial management did you adopt? In your team, is RT practiced? And is there any pre-established flow in your unit for when the rapid test is reactive to the HIV virus? " And in the Reality Observation stage, following the presentation of the complex case of diagnostic development of HIV virus infection and a campaign without planning of RT for sexually transmitted infections, the following triggering questions were presented in the forum: "Reflect on how the process of implanting RT for HIV actually occurs in your health unit and answer: Is there any similarity of your practice to the operation of Figueira Nova I (where the clinical case is set)? How do the professionals of your team articulate when it is reactive?"

Figure 2– Module Interface with the triggering questions for discussion for the first Forum.

Source: Author with UNA-SUS/UFCSPA Team.

The qualitative analysis of the object of research allows knowledge construction and has all the requirements and instruments to be recognized and considered as a scientific construct[14]. In order to systematize and analyze the data, extracted from the textual production of the activities throughout the module, the research used the technique of content analysis through the thematic approach proposed by Bardin[15]. After an exhaustive reading of the material, the content was organized in order to systematize the information obtained in the educational intervention. In that way it was possible to identify the main groups according to the regularities of the content analysis of the discourse and the frequent and unique meanings found in the texts. Subsequently, data were organized into categories and subcategories. The categories were defined considering the guidelines of the Brazilian National Health System (SUS) and 90-90-90 target: scenarios of practice, comprehensiveness and permanent education in health[2,4].

The discussion of the results took into consideration the SUS Directives, Permanent Health Education, the Brazilian Legislation in force as well as references related to the use of HIV RT.

Considering the ethical issues inherent in human research, this project was submitted to the UFCSPA Ethics and Research Committee with Human Subjects, whose CAAE 43360115.5.0000.5345 and Opinion No. 1,115,708, following the guidelines of National Health Council Resolution 196/1996/MS. All participants accepted the Free and Informed Consent Form. This research is part of the dissertation to obtain a Master´s Degree in Health Teaching of UFCSPA, supported by Edict Capes n.024/2010, *Pró-Ensino na Saúde*.

Results and discussion

The results were consolidated and will be presented based on the following categories of analysis: practice scenarios, comprehensive care and permanent education in health, highlighting the specificities of the trajectory reported by the students in the distance-learning module.

Practice Scenarios

Among the experiences that the 14 participants of the research shared, ten of them had never articulated the diagnostic disclosure of HIV infection, 3 only once and 1 only 2 times. The slow implementation of this instrument in health units, the lack of knowledge of its diagnostic and not screening value were mentioned by students when describing their professional reality. Selection for access to HIV RTs to pregnant women and clinically suspected users is referred to as usual practices. The Federal Council of Medicine regulates the physician to check in the consultations if his patients have performed serological tests for HIV and other sexually transmitted infections. It is up to the physician to guide the patient, as the case may be, about the necessity, the opportunity or the convenience of its execution[3].

"At the medical consultation, in cases of need for rapid testing request, it has been well accepted by all patients ". (K)

"So far, I have never been in a position to disclose a positive HIV test to my patients. The rapid test in my team was already performed by the nurse, about 3 tests in total, in 7 work months, and there were no positive cases. And when I needed the test, I unfortunately had no more...". (M)

The group presented management difficulties in the organization of the work process and in the agreements on the adoption of rapid tests in their work units, even counting with public policies affirming that access to HIV diagnosis and treatment are fundamental to guarantee the highest level of health for people living with HIV. Campaign strategies to expand access to voluntary testing and counseling with passive and partial approaches should be reconceptualized using a more active and comprehensive approach, without being coercive[16].

"In the unit where I worked during the PROVAB in XX city, we had two teams and, for most of the year, we worked without nurses. With this the rapid tests were concentrated in the Central Post of the municipality, the same where positive cases are followed". (F)

"At the UBS where I was working, a campaign was carried out to perform rapid tests on a specific day of the month and 30 tests were performed, none of which were positive ... I talked to the nurse about the flow of results and she explained to me that they should be referred to the CTA for the Social Worker to refer to the Reference Center on Tropical Medicine in the capital XX". (L)

> "Also as it is a new test in our system, we have not yet elaborated a strategy regarding the work flow and it has not yet started to be used". (B)

Even with the group reporting the adversities of using the test as an instrument for diagnosis, the discourses show the desire for change performing this test in the PHC setting. The 2015 Treatment Handbook warns that when HIV testing focuses on independent testing centers, it is anticipated that there will be demands on the part of users who admit being at risk for the infection and are thus interested in knowing their serological status. The goal is to prevent diagnostic development from occurring at an advanced stage of infection, which does not contribute to the effectiveness of the treatment and promotes the spread of the virus. Several countries have shown that the most proactive and effective path consists in using various harm reduction strategies to broaden the reach and impact of testing services[2,16].

> "No one is denied the performance of the tests, are advised in regard to the diagnosis price of STD diseases, and their prevention with the use of condoms, it is the first time I work in a country with high STD rates, but I trust that with the work of we will all be able to reduce these high rates". (J)

> "The tests are performed every day in the morning and afternoon shifts, with no need for scheduling ". (K)

The difficulties of implementing the rapid test were identified as caused by several reasons and grouped into subcategories, such as public management and its limited resources for diagnosis and treatment. As it fell out of the scope of this research, the reasons for the shortage are not specified, whether if it occurs for lack of supply of the products by the competent agencies, for failure of the unit in requesting or other reasons. In the 90-90-90 target, it is noted that some implementation issues

such as drug shortages, inadequate availability of second and third line antiretroviral regimens, barriers to their acquisition, and costs of the inputs required for the diagnosis have hampered the intensity of treatment in some countries [2]. In this scenario, it is considered that the tests should be prioritized for the key groups, e.g. pregnant women, not being able to extend them to the whole community, as can be perceived in the speeches:

> "The rapid test arrived shortly in my unit in small quantities, as well as the tests for syphilis and hepatitis. What was agreed in the team was that, given the minimum number of tests available, we would put them at the disposal for the pregnant women only". (B)

> "As the amount of kits we receive is low, the team uses them for prenatal testing only". (A)

The group highlighted the often fragmented care within the team as well as regarding the support network, influencing the clinical management of care[4]. Linkage and adherence strategies with health professionals and care services are fundamental to initiate and maintain care and treatment processes of patients diagnosed with HIV virus infection. According to the 2013 Guideline of the American Association for Infectious Diseases on the Initial Management of Individuals with HIV, the long wait for the first visit proved to be a negative predictor of adherence to care[17].

> "So far I have not had the opportunity to disclose a reactive rapid test for any patient, as they are scheduled by the STD team assigned to a specific doctor who performs the treatment and follow-up of HIV positive patients and through it they are sent to psychological care". (K)

> "In my unit, the tests are carried out by a nurse and a nursing technician, which in two rapid tests positive for HIV are scheduled to

> show the tests to the specific doctor who performs treatment and follow up to positive patients, The doctor is the one to give the news, explain the disease, clarify doubts of the patients and refers to psychological care". (K)

The World Health Organization has sought several partnerships in its efforts to optimize therapeutic schemes, expanding the opportunity for care in the territory and applying mobile diagnostic tools, such as rapid tests[18]. In Southern Brazil, launching of the clinical protocol in PHC in December 2016, suggest the early treatment of asymptomatic carriers with CD4 above 500 cells/mm^3 [19]. Nevertheless, roadblocks such as the one below, impact on the early onset of treatment and are testimony of the lack of resources to meet this demand:

> "After confirmation, early drug therapy (ART) begins. Even without counting the leukocyte parameters. There is only AZT for initial management. There is no TDF or 3TC. However sometimes there are no test kits". (D)

Comprehensiveness

Comprehensiveness along with access, longitudinality, coordination, family-centred, family approach and community orientation represent the organizational attributes of PHC. The comprehensiveness attribute prioritize actions of prevention and health promotion not neglecting the care measures. This guideline assures the care to the citizen in the three spheres of health care, with a comprehensive approach to the individual[4]. However, as in the development of teamwork, there is scarce attention to the formative process of medical education[9].

The group of students of the specialization in Family Health of UNASUS/UFCSPA bears a profile of: physicians working in PHC; linked to the Programs of Recognition of

Primary Care (PROVAB) and Mais Medicos; and they have already studied the modules of SUS and PHC guidelines. Comprehensiveness is defined in this research as a category of content analysis that includes 03 subcategories: feelings regarding the practice, access to the test and attention to the user. Comprehensiveness has to do with the structuring of person-centered care as a starting point for any action. Thus, it envisages the remodeling of care practices according to the singularities of the subjects, encouraging humane reception, autonomy and bonding; as well as valuing the subjectivities related to health work. Reflections on comprehensiveness are opportunities to rethink the practices and structures of public health services, many of which are still characterized today by the discontinuity of care[20].

> "Any act of disclosing a sad result for a person brings with it feelings of guilt and denial on the part of the patient, being a difficult moment for starting the initial management and the behavior regarding the patient". (N)

There are references to successful experiences, described in the Brazilian Response to HIV and AIDS. The dissemination, for example, of the "Viva Melhor Sabendo" ("Live Better Knowing") initiative exemplifies an alternative of increasing access to diagnostic technologies to increase the possibility of knowing the serological status, according to the perspective of the first part of the 90-90-90 target. This project promoted campaigns and testing on key groups on the street. In all, 15,833 individuals were tested over 11 months, targeting transvestites, transsexuals, female and male sex workers, men who have sex with other men and drug users. The analysis of the results was that 2.6% of the tests were positive. It is expected that following knowledge of the serological status this will contribute to the containment of virus transmission[21].

Follow-up after diagnosis may be lost in many cases due to lack of proactive interventions and support services. Campaigns can disseminate and mobilize the most vulnerable communities, working in partnership with those groups, highlighting the

benefits of both therapeutic and secondary HIV treatment in the first place, including prevention of transmission to third parties. Misconceptions about HIV testing and the relevant options for the care of individuals with HIV infection should be clarified whenever possible[16]. At the beginning of the Module, talks in the forums portrayed the ignorance of the care pathways at the time of diagnosis or the existence of a flow to guide the possibilities of a comprehensive approach.

> "The rapid test is the initial way to go ... then a new rapid test was requested ... However the definitive serological diagnosis is performed in the capital of XX by the ELISA". (D)
>
> " And if necessary we can call the SAE and ask for help". (I)
>
> *" In the city that I work, I do not know if there is a flow". (H)

The organization of the PHC care pathway is a necessity, since there is a priority to maintain adherence to antiretroviral therapy. In this proposal, there is a systematic search of 13 published studies and 3 conferences, giving voice to a scarcely explored topic: what intervention strategies are more effective to promote evidence-based adherence to care? One of the evidence-based strategies includes bringing the team closer to the community and to the user through instructional materials, including personalized items by staff, reducing barriers to access. Another intervention strategy includes community actions to demystify the disease involving other meanings and the importance of establishing care therapy[18]. The difficulty in the care pathway is an important factor emerging in the observation of the Alisson Complex Case presented in the Module. The same illustrates the difficulty of the team in disclosing the diagnosis to the patient and guiding the management line during a campaign promoted by the health unit in the fictional city of Santa Fe, as the reflection of the actions to be taken if the rapid test was reagent were not previously considered. The students were stimulated from the complex case to observe the reality as well as the

existence of a reflection on the practice of the test and related to how to handle it appropriately in case this happened.

Table 1: Reflecting on the care pathway for the first steps in the HIV reactive RT

Thoughts or Flowchart known for the first steps	Number of Students
Non existent	09
Present and consists in referral to infectologist	03
Present and has several actions for reception and management	01
Not clear	01

The speech section described below illustrates the contents of the table:

> "When I read the Alisson case (complex case that illustrates the Module), I noticed the team's difficulty in how to proceed after the reagent result.There was no pre-arranged flow and maybe some behaviors were missing, not merely the referral of the patient". (B)

The data in Table 1 conflict with the second step of the 90-90-90 target, which aims to rapidly intensify HIV treatment globally regardless of the CD4 count value. That is, the total number of people who know to be carriers of the virus will be the number of people chosen for the treatment. The profile of the sample shows that the possibility of offering the RT to HIV as a diagnosis was not linked to the reflection on how it should proceed if the examination was positive. It is necessary to know and discuss the management possibilities before assuming this goal. Some international guidelines such as in Brazil allow the initiation of antiretroviral therapy independent of CD4 counts, using a human rights approach, with the right to test and treat all[2,19].

> "The city where I work has been practicing the rapid test for 1 year, 86 tests were performed, none of them reagent. Despite having a flow chart established by the Ministry of Public Health of Brazil, the team (in a general sense) is not prepared to face a case where the patient has to be exposed to a reactive result". (N)

Comprehensiveness in patient care requires a training process to master the therapeutic possibilities and transform the practice of patient care at the time of diagnosis. Protocols and guidelines were organized by the stimulating pedagogical proposal of the PM throughout the Module, starting from the experiences by the students titled Reality, stimulating the student to be conscious and an actor in the transformation of reality[11].

Permanent Education in Health

The application of HIV RT is supposed to be carried out by trained professionals, being a powerful tool for the diagnosis of HIV in Brazil[22]. Of the 14 participants, 9 described that they did not have the opportunity of permanent education on this subject. The difficulties related to the category of Permanent Education in Health present the subcategories titled "insecurity in practice" and "ignorance of the care pathway" in the observation of reality.

> "those who had training had it only for the technique, but they often complain of insecurity to apply it and how to approach the patient if the result proves to be reactive. Due to these difficulties we have not yet begun to use them". (B)

> "we felt uncertain about how to proceed with a reactive result". (L)

" in the case of positive test, I (or the nurse) would probably be chosen to relay the news (in my case, without much experience for this)". (M)

"training is very important in making safer decisions". (E)

Substantially increasing demand for RT is an essential aspect to be considered in expanding access to treatment. This requires a strong and sustained investment in community-based HIV education programs. In addition, support needs to be intensified to strengthen community systems in order to raise awareness of the availability of simple and easily tolerable regimes, increase access to user-friendly testing options, and reduce stigmatizing attitudes[16].

The last activity of the Module provided for the students to build an RT-reactive user management flow guidance to be applied in their health unit, discussing with the team the potential of a comprehensive care and studying the possibilities of the care network of the region. The points explored in the flowcharts were organized in a table along with their frequency.

Table 2: Points outlined in the Flowcharts of the Initial Management of Users with Rapid Reagent Test in PHC and the frequency with which they appeared in the activity

Issue in patients´flow	frequency
1-Pre Test Counseling	6
2 Post test Counselling	11
3. Train health Team	2
4. Notify SINAN	8
5. Request Image Tests	11
6. Schedule office visit	4
7. Refer to specialist	7
8. Shared treatment (Primary care + specialist)	3
9. Check vaccines	4
10. Check for TB	3
11. Perform anamenesis and physical examination	5
12. Request check-up of partner if needed	1
13. Screening for cancer	2

14. Screening for cardiovascular risk	3
15. Evaluate contraceptive needs	1
16. Management of emotional symptoms if needed	5

From the closing of the Module and up to a month later, a questionnaire with structured questions and an open questionnaire were made available to evaluate the students' perception about the educational intervention and the teaching methodology, since this was the first time that PM was used in this Specialization Course. The perception of all students (100%) was that the teaching methodology facilitated learning, that the organization of the content facilitated their understanding and that the Module favored the articulation between theory and practice. This active methodology, by its very essence, is stimulating[8], and it is aligned with the rationale of curricular reforms imposing pedagogical challenges for the articulation of theory with practice[9].

The existence of the relationship between the contents and the professional practice of the student was also evaluated. All answered that "yes, there was", where 13 responded a lot and 1 answered “not much”. When asked if the module stimulated them to broaden the research on the subject of HIV, 11 responded that yes, a lot, 1 answered yes but not much, while 1 answered yes, but in a very small proportion.

Final considerations

The 90-90-90 goal promotes accountability of the care, community and public management team. A clearly articulated goal allows the various actors to identify their respective roles and responsibilities, thereby accelerating progress and critically assessing gaps in order to accelerate the response towards a consensus framework to erradicate the HIV epidemic by 2030[2].

Good quality health care in the HIV care line is a result of the organization of surveillance, monitoring of implementation and supervision, coordination, technical

assistance policies, technical norms and guidelines[16]. However, even in the situation described in capitals, such as what is reported in Porto Alegre, the perception of professionals and users still demonstrates the need to rethink RT practices to benefit the needs of users[23]. Another research in this capital presents the capacities in articulation with the matrix support as an important strategy for the change of the axis of HIV care shifting from the specialized service for the PHC[24]. Thus, with the changes in the diagnosis and treatment approach in PHC, the permanent education in health is an alternative to guide this process in a cooperative way.

The results show that the students of the Module "Initial Management of Users with RT reactive for HIV" present difficulties in adopting this instrument in PHC and on its clinical management. As it was an optional module in the specialization course, it is inferred that the students were willing to participate motivated by the search of knowledge to modify their actual practice.

The process of investigation, apprehension of reality, as well as the triggering and evaluation of qualitative methodological tools requires dialogue, reflexive knowledge and commitment to the concrete reality, which implies the effective recognition of the subject in the object. It is from this circular and dynamic perspective that action-research finds resonance and support for the conquest of a new space and/or the achievement of new knowledge in the context of health[25].

However, in order to achieve the 90-90-90 target by 2030, unprecedented action is needed to advance the early start of antiretroviral therapy. Delayed treatment allows the epidemic to continue moving forward. Inspired by the progress made so far, the entire global community must commit itself in order to avoid missing this historic opportunity to face this epidemic[2].

In this trajectory, several obstacles must be overcome. Approximately 130,000 people infected with HIV in Brazil are unaware of their serological status. In addition, despite the current reduction in the interval between diagnosis and initiation of treatment, it is estimated that almost one third of patients linked to the public service remain untreated. The analysis of the trends in the indicators related to the continuous care cascade showed that, in spite of some challenges, Brazil is on the right track to

place all patients who are aware of their serological status under treatment and to achieve high rates of viral suppression. In order to move forward on these results, it is necessary to continue to invest in innovative and evidence-based approaches[1].

Despite the limitations of the sample, compromising the generalization of the research, there is an unquestionable need to reflect on the complexity of the diagnostic disclosure of HIV infection and the initial management of patients. The permanent education in health using Active Methodologies can be an alternative to reach this goal, as foreseen by law. The question about how to perceive the use of PM in the distance learning modality showed that the Module fulfilled its role in guiding the students in ways to observe their reality and propose viable solutions that can transform their professional practice regarding the initial management of the user with HIV RT-reactive test in the context of PHC.

Collaborators

Ana Amélia Bones, Márcia Rosa da Costa e Silvio César Cazella participated actively in the discussion of the results and participated in the review and approval of the final version of the work.

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