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HIV/AIDS management at the primary care level in Brazil: a challenge for the Unified Health System?*

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ABSTRACT *In Brazil, the Unified Health System (SUS) consists of a hierarchical and regionalized network of health services coordinated from the primary health care (PHC) level, which is also the entry point into the system. Recently, as a result of new guidelines and experiences in Brazil, PCH has been assigned a more substantial role in the care and management of people living with HIV/AIDS, tasks traditionally performed at specialized clinics. The present article contextualizes and explores the problems involved in this recent process of providing decentralized care to people living with HIV/AIDS in the context of the SUS. Since 2011, new diagnostic technologies (such as rapid testing) have become available at PHC units in Brazil, expanding access to testing and leading to an increase in the number of HIV diagnoses performed at the PHC level. Since 2013, new guidelines and recommendations have also supported care for people with HIV/AIDS in PHC units. The present article examines the relationship between PHC and specialized care, issues of access, stigma, and confidentiality in PHC, and the mode of organization and functioning of family health teams, especially the formal link between residents in catchment areas and health teams and workers. In conclusion, many challenges–moral, ethical, technical, organizational, and political–have to be faced in order to increase access and quality of care in the context of PHC for people living with HIV/AIDS in Brazil.*

Keywords Primary health care; acquired immunodeficiency syndrome; comprehensive health care; Brazil.

Brazil's Unified Health System (SUS), established in the Constitution of 1988, is the legal and institutional manifestation of the struggles of the health sector reform movements. Its fundamental principles and guidelines are universality, equity, comprehensiveness, decentralization, and social control. The system consists of regionalized hierarchical health care networks (known by the Portuguese acronym RAS) (1), designed to deliver integrated, comprehensive, and rationalized care to address the problems created by the fragmentation of health services and the cost of care (2, 3).

Internationally, certain attributes have been embedded in the concept of primary health care (PHC), significant among them its role as the first contact with the health system, along with accessibility, longitudinality and coordination of care, a comprehensive approach, and cultural competence (4). These attributes give PHC (also known as "basic care" in Brazil) the challenging mission of operating as the first organizational level and preferred point of entry to the SUS through the RAS networks, with a high degree of effectiveness in resolving clinical and public health issues and

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integration with the other services that make up the RAS networks.

In Brazil, the SUS reports progress and innovations in areas such as immunization, mental health, PHC, HIV/AIDS, and transplants, which have occurred more as a result of specific limited programs and policies than a systematic and integrated effort (3). This is due, at least in part, to problems such as underfunding, management by three independent federated entities (Union, states, and municipalities), the influence of the private health sector, the significant regional differences in Brazil, and the context of SUS implementation (unfavorable to universal social protection policies), which end up creating "several SUS". Socioeconomic and regional disparities are also expressed in terms of health and the health system, since administering such a decentralized system is a complex challenge (5).

New national guidelines and local activities have recently put PHC at the forefront in the fight against HIV/AIDS, with the role of continuing and expanding promotion, prevention, and diagnostic activities and supporting users living with HIV. Until recently, the care component of HIV/AIDS policy—an area in which Brazil has been prominent on the global stage—has been under the purview of specialized services.

In light of this, the purpose of this article is to provide a context for the recent decentralization of care to PHC for people in Brazil living with HIV/AIDS—a topic still rare in the scientific literature—and to analyze the potential and challenges, such as the right of people with HIV/AIDS to comprehensive care (considering health needs, access to care and services, as well as human rights), on the one hand, and the need to strengthen PHC and its incorporation in the RAS health care networks, on the other. Here, we emphasize the understanding that public policy-making and policy implementation are sociopolitical processes involving different stakeholders and projects/agendas with different actions and reactions on different levels and in different arenas, such as government, the health services, and civil society.

HIV IN BRAZIL

The first HIV cases date back to the early 1980s in the United States. Brazil's response to the epidemic began in 1982, prior to the creation of the SUS, with the establishment of the first community mobilization organizations, the São Paulo state program (Southeast region) in 1983, and the Ministry of Health's national program in 1986 (6). In the ensuing years, the epidemic came to be characterized by intense collaborative responses involving both people living with HIV/AIDS (PLWHA) and the technical areas (7, 8).

The history of Brazil was marked by the challenge of providing a long-term response to the epidemic. During the first two decades, joint efforts among different sectors and stakeholders led to loan agreements with the World Bank to finance prevention activities. Brazil also innovated by providing antiretroviral drugs through the SUS, contrary to the recommendations of the World Bank. This measure led to a radical change in clinical status and epidemiological profiles, resulting in lower mortality and longer life expectancy for PLWHA (7, 8).

Throughout this period, the clinical model was specialized care, generally provided by infectious disease physicians. Specialized outpatient health services were provided in polyclinics and hospitals. Diagnoses were made in these units and later, in testing and counseling services (TAC). PHC participation in this process was intensified only after 2000, when PHC became responsible for prevention and counseling, and, recently, testing (9, 10). Support for PLWHA through risk stratification was the final stage in the decentralization of care and is just beginning in some municipalities.

Thus, more recently, the scenario for responding to the HIV/AIDS epidemic has significantly changed in Brazil in an attempt to meet global control targets (11). Salient features of prevention include the use of rapid testing in the SUS and its gradual decentralization to PHC under the Family Health Strategy (ESF) and to mobile units, in partnership with civil society; the expansion and standardization of postexposure prophylaxis (PEP) measures; and the use of pre-exposure prophylaxis (PrEP) for specific populations in the SUS. Salient features of care, in turn, include the eligibility of any PLWHA for antiretroviral therapy, the adoption of preventive therapy, and the use of fixed-dose combination drugs as the first line of treatment, with the inclusion of new drugs.

According to official epidemiological data, a total of 882,810 AIDS cases were reported in Brazil from 1980 to 2017, 576,245 (65.3%) in men and 306,444 (34.7%) in women. The greatest concentration of cases was in the Southeast (52.3%) and South (20.1%) regions, followed by the Northeast (15.4%), North (6.1%), and Center-West (6.0%) regions. From 2007 to 2017, 194,217 HIV cases were reported in Brazil. In 2014, the principal mode of transmission among people aged 13 and over was sexual, in both sexes. Among people under 13, virtually all cases were the result of vertical transmission (12).

PHC IN BRAZIL

PHC is a strategic element of the RAS health care networks within the SUS. The Family Health Strategy has been considered a strategy for reorienting the model of care in the SUS, having been expanded to virtually all municipalities and regions in Brazil through federal financing from the Ministry of Health as part of the intensified decentralization process launched in the 1990s. The Family Health Strategy has greater coverage in territories with populations in situations of greatest social vulnerability (13). The country currently has 41,000 family health teams, covering roughly 65% of the 204 million Brazilians.

Under the National Primary Care Policy (PNAB), makes the RAS networks responsible for basic health services and makes them the preferred point of entry to PHC, given their response capacity and their ability to coordinate care for users. Within their territorial areas, the RAS networks are responsible for user registration, and teamwork, among other areas, engaging in health promotion, disease prevention, treatment, health maintenance, rehabilitation, and harm reduction activities, considering the cultural and socioeconomic context of individuals and communities (14).

PHC in Brazil is provided mainly through family health teams consisting of a general practitioner, nurse, nurse-technician, and community health workers (CHWs); they can also include oral health professionals and support from psychologists, nutritionists, physical therapists, psychiatrists, etc., forming Family Health Support Groups that discuss cases, provide joint care, and conduct group activities to strengthen PHC capacity to deliver health care. Each family health team is responsible for the care of 3,000 people

on average, a figure that can vary, depending on the characteristics of the territory and population (degree of social vulnerability, for example). CHWs live in the neighborhood where the services staffed by the family health teams and the population under their care are located and are considered mediators between population and the PHC services. Primary care services, known generically as primary care units or 'basic health units' (*unidades básicas de saúde*, UBS), are managed by the municipalities, based on national guidelines and shared financing among the municipalities, states, and the central government.

The three main lines of action for PHC under the SUS are: attending to spontaneous demand, guaranteeing access, and delivering continuing care and services for public health problems/risks (15). PHC is therefore organized geographically, with a high degree of attention to the social dynamic and the living conditions and lifestyles of the population. In a country as diverse, unequal, and vast as Brazil, different PHC contexts coexist, with certain common features (16).

Notwithstanding its progress, PHC, like other components of the SUS, has its constraints and problems. It should be noted, though, that certain PHC practices and activities are already widespread in the areas of child health, prenatal care, and care for people with diabetes and hypertension. However, while PHC activities have been implemented in the fields of mental health and rehabilitation and for conditions such as HIV/AIDS, they are less characteristic of primary care and are only partially handled at that level.

The period 2011-2014 marked an important inflection point in the PNAB and other national policies promoting PHC in Brazil, with the creation of the *Mais Médicos* (More Doctors) program (17). In addition, recent regulatory changes in the PNAB in 2017 (in the context of adverse social, political, and economic conditions in Brazil and the SUS) have been the focus of many protests and much concern about the risk of weakening the Family Health Strategy and strengthening a lingering PHC model that predates it.

PHC FOR PEOPLE LIVING WITH HIV/AIDS IN BRAZIL

Between 2011 and 2012, the Ministry of Health introduced new diagnostic technologies in PHC, with emphasis on rapid testing (for pregnancy, syphilis, HIV, and other conditions), increasing access to HIV testing and diagnosis in PHC in every region in the country. In 2013, the Ministry of Health also issued guidelines and recommendations for incentives to support people with HIV/AIDS (presenting a low risk) in primary care in the municipalities (18). Meanwhile, some Brazilian municipalities that had made major investments in organizing PHC, such as Curitiba and Rio de Janeiro (located in the South and Southeast regions, respectively), were actually decentralizing care for people with HIV to PHC (18). Although health promotion and HIV prevention activities were already widespread among family health teams, the diagnosis of new cases (in all regions) and, primarily, support to users who tested positive (in some municipalities) are very recent activities surrounded by controversy and hardly studied as yet.

Considering the trajectories in the construction of PHC in Brazil and in the Brazilian response to HIV, formulas developed in Brazilian public health and other disciplines, and the overall context of the SUS and Brazil, certain aspects require special attention. The first of them is the relationship between PHC and specialized care, given the central role of physicians in the care of PLWHA. Although "shared" between the two "levels" of care, according to the program, the care provided by the health services can lead to tension. In the Brazilian experience, general practitioners in PHC may be viewed by specialists as "recently trained" or "at the end of their career," with inadequate training for "managing" the infection, an excessive workload, and duties inappropriate for physicians, resulting in inadequate care for PLWHA. Does this represent a confrontation between two forms/concepts of medical practice or between two epistemologies of care, one more comprehensive and holistic and the other more biomedical? (19)? How should "shared care" be understood in this case? Proposals include structured support, where specialists and general practitioners come together around specific cases and engage in activities such as case discussions and joint consultations. This modality is already present in the experience of the Family Health Support Groups and may prove fruitful.

A second aspect is the question of access, stigma, and confidentiality in PHC. Part of the rationale for decentralizing care for PLWHA is the ease of access to care. However, the literature points to fear among PLWHA that their HIV status will be disclosed to the community through the sharing of information and decisions by the multiprofessional team, as occurs with family health teams (10). To what extent can territoriality increase the opportunities for care or, on the contrary, exposure to preconceptions?

The third aspect is related to the way in which family health teams are organized and operate, especially the formal links between residents and teams. Each family health team is responsible for a geographical area, with links to the population that resides or, in some cases, works there. There are some limitations to this type of organization. On the one hand, a sense of linkage should presuppose a relationship of trust – something important to a person whose life is affected by an HIV diagnosis; and a broader concept of linkage could lead to closer ties between health professionals and users, making it possible to have conversations about issues such as prevention, sexuality, drug use, etc., strongly impacting the user's actual linkage to a family health team. On the other hand, there is the fear of exposure and stigma, which can cause some users to prefer to receive support far from where they live.

This leads us to believe that special attention is needed to the real links that exist or are developed between users and family health teams, and to the establishment of flexible rules to address the risk of failing to care for users and guarantee their right to health, without barriers, due to the way the health service is organized and operates.

FINAL CONSIDERATIONS

HIV/AIDS and PHC policies in Brazil have had divergent trajectories that have recently begun to converge - initially, by assigning an important role to HIV testing and diagnosis in PHC (with greater emphasis on pregnant women) and, subsequently, by means of municipal guidelines and experiences in the decentralization of care for PLWHA to PHC, sparking controversy and new efforts. This is a social innovation in health that merits study.

The purpose of this article was to provide a context for this decentralization process and to highlight aspects that create tensions, challenges,

and opportunities, while considering the recent nature of this movement and the existence of few studies and little research. It is important to point out the different nature of the challenges: moral (related to sexuality and the stigma associated with sexual practices), ethical (related to secrecy and confidentiality in the context of territorialized teamwork), technical (clinical management and professional training), organizational (internal) (PHC flexibility: whether it can adapt its modes of organization to users' needs and expectations), organizational (external) (support and interaction of family physicians with infectious disease specialists in specialized care), and policy (management of the agenda and dialogue between different stakeholders and points of view). We believe that tackling these challenges can be positive for PLWHA, possibly improving to care and quality of care, and enabling PHC to meet these and other challenges.

Conflicts of interest. None declared.

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Cuidados de pacientes con VIH / sida y atención primaria en Brasil: desafíos para la atención en el Sistema Único de Salud?

RESUMEN

En Brasil, el Sistema Único de Salud (SUS) prevé la organización de una red jerarquizada y regionalizada de servicios de salud, teniendo la atención primaria en salud (APS) como ordenadora y puerta de entrada para los servicios. Recientemente, nuevas directrices y experiencias brasileñas otorgaron a la APS un papel de mayor protagonismo en el tema de las políticas de VIH/sida, que hasta entonces desarrollaban su componente asistencial centralizado en servicios especializados. Este artículo contextualiza y explora los problemas de este reciente proceso de descentralización del cuidado a las personas que viven con VIH/sida en el SUS. A partirde2011, nuevas tecnologías diagnósticas (como las pruebas rápidas)fueronimplantadas en la APS en Brasil, ampliando el acceso a la prueba y promoviendo un aumento del número de diagnósticos de VIH en la APS. A partir de 2013, las directrices y recomendaciones incentivaron también el seguimiento de las personas con VIH/sida en el marco de la APS. En este contexto, el presente artículo examina la relación entre la APS y atención especializada, los temas de acceso, estigma y confidencialidad en la APS y el modo de organización y funcionamiento de los equipos de salud de la familia, así como la vinculación formal entre los habitantes y los equipos de APS. Se concluye que es necesario enfrentar variosdesafíos(de orden moral, ético, técnico, organización y política) para ampliar las posibilidades de acceso y la calidad del cuidado en la APS para las personas que viven con VIH/ sida en Brasil.

Palabras clave Atención primaria de salud; síndrome de inmunodeficiencia adquirida; atención integral de salud; Brasil.

Cuidado, HIV/Aids e atenção primária no Brasil: desafio para a atenção no Sistema Único de Saúde?

RESUMO

No Brasil, o Sistema Único de Saúde (SUS) prevê a organização de uma rede hierarquizada e regionalizada de serviços de saúde tendo a atenção primária à saúde (APS) como ordenadora e porta de entrada para os serviços. Recentemente, novas diretrizes e experiências brasileiras designaram para a APS um papel de maior protagonismo no tema das políticas de HIV/Aids, que até então desenvolviam-se, no seu componente assistencial, centralmente em serviços especializados. Este artigo contextualiza e problematiza esse recente processo de descentralização do cuidado às pessoas vivendo com HIV/Aids no SUS. A partir de 2011, novas tecnologias diagnósticas (como os testes rápidos) foram implantadas na APS no Brasil, ampliando o acesso à testagem e promovendo um aumento do número de diagnósticos de HIV na APS. A partir de 2013, diretrizes e recomendações incentivaram também o acompanhamento de pessoas com HIV/Aids no âmbito da APS. Nesse contexto, o presente artigo examina a relação entre APS e atenção especializada, as questões de acesso, estigma e confidencialidade na APS e o modo de organização e funcionamento das equipes de saúde da família, notadamente a vinculação formal entre moradores a equipes. Conclui-se que o enfrentamento de vários desafios - de ordem moral, ética, técnica, organizacional e política - é necessário para ampliar as possibilidades de acesso e a qualidade do cuidado na APS para as pessoas vivendo com HIV/Aids no Brasil.

Palavras-chave Atenção primária à saúde; síndrome de imunodeficiência adquirida; assistência integral à saúde; Brasil.